Oral Testimony on behalf of the
New York State Division of Human Rights

May 24, 2019

INTRODUCTION

Distinguished members of the committee, thank you for the opportunity to discuss the important issue of sexual harassment in the workplace on behalf of the New York State Division of Human Rights. My name is Melissa Franco and I am the Deputy Commissioner for Enforcement. I am joined here by my colleague, Gina Martinez who is the Deputy Commissioner of Regional Affairs and Federal Programs.

The New York State Human Rights Law prohibits discrimination on a wide range of protected classes including prohibiting sex discrimination and sexual harassment, in employment, housing, credit, places of public accommodation, volunteer firefighting, and educational institutions. The Human Rights Law also provides separate protections against retaliation. Last year, Governor Cuomo signed a groundbreaking package of legislation that strengthened protections against sexual harassment. Now, employers can be held liable under the Human Rights Law to non-employees performing work in the workplace, for example, independent contractors, consultants, service providers, delivery persons – who are sexually harassed. This applies to all employers, of any size, public or private. Today *any* individual in *any* workplace – of any size, public or private – is entitled to protection against sexual harassment under the Law. If an employer is found liable under the Human Rights Law for sexual harassment, they may be ordered to provide injunctive or appropriate affirmative relief, back and front pay and compensatory damages for emotional distress. Civil fines and penalties, and attorney's fees may also be awarded in sexual harassment cases.

The Division of Human Rights (DHR) was created in 1945 to enforce the Human Rights Law to ensure that all New Yorkers have an equal opportunity to participate fully in the economic, cultural and intellectual life of the State. DHR investigates, hears, and adjudicates complaints filed by individuals as well as those brought by the Division itself to address systemic discrimination. DHR also engages in outreach and education campaigns designed to inform the public on the effects of discrimination and their rights and obligations under the Law; and issues policies, regulations and guidance implementing the Human Rights Law and addressing issues of discrimination and harassment.

DHR has approximately 164 full-time employees, including 63 investigators, at twelve regional offices statewide. The agency receives over 6,000 individual complaints annually, of which approximately 80% relate to employment. For any claim of discrimination or harassment, individuals may file a complaint with DHR within one year of the last act of alleged discrimination. Complaints with DHR can be filed in person at any office, or can be sent in via email, fax or mail. If individuals need assistance filing a complaint, they can call our hotline, or call or visit any of our regional offices. An individual does not need an attorney to file a complaint or utilize our process. DHR provides free translation and interpretation assistance at all offices.

Once a complaint is filed with our agency, it is reviewed to determine if DHR has jurisdiction over the conduct alleged. Next, the investigators conduct an investigation into whether there is probable cause. As a part of this process, investigators may issue written requests for information, visit the site of the alleged incident, and meet with the parties and/or witnesses. Once DHR receives and files a complaint, it is served upon the respondent, who is asked to respond to it in writing. Any responses received are sent to the complainant who is given an opportunity to provide a rebuttal. Once a final determination is made, both parties will receive a written

determination in the mail. Currently, 97% of all claims investigated by DHR are completed and determinations made within 180 days. During 2018, the average processing time to investigate a sexual harassment case at DHR was 172 days.

If the investigator finds no probable cause or lack of jurisdiction, the complaint is dismissed. A complainant may appeal this dismissal within 60 days to State Supreme Court. If a determination of probable cause is found, the claim proceeds to a public hearing. If a complainant does not have private counsel, DHR will assign an attorney to the claim. If a settlement is not reached the case will be calendared for a public hearing before a DHR Administrative Law Judge or ALJ.

If the complainant does not have a private attorney, the assigned Division attorney interviews the complainant, reviews the evidence in the file, formulates a hearing strategy and puts forth the evidence at the hearing. The Division attorney may also conduct cross examination of the Respondent's witnesses and rebut any other evidence entered by the Respondent. A Division ALJ reviews all of the evidence and drafts a recommended order for the Commissioner's consideration. The parties have 21 days to file objections to the recommended order. The Commissioner makes the final determination as to whether the Human Rights Law has been violated and may award any available remedy under the Law. Either party may appeal an order directly to the Supreme Court of the State of New York in the county where the discrimination is alleged to have occurred. DHR attorneys appear in any cases on appeal to support our findings of discrimination in these matters.

DHR is also empowered by the New York State Legislature to oppose systemic patterns of discrimination through Division-initiated investigations and complaints. The Division Initiated Investigation (DII) Unit is responsible for identifying, investigating, and bringing complaints to

remedy large-scale and systemic discrimination in New York State. The Unit identifies potential targets through various means including referrals from other State agencies, anonymous tips, newspaper articles, and meetings with various advocacy groups. Once a potential target is identified, the Unit uses various investigative tools to gathers evidence to determine if a potential target has violated the law. If the evidence gathered shows a violation of the law has occurred, the Unit will file a complaint on behalf of the State of New York. It will then be investigated by a separate regional DHR office to determine whether there is probable cause to believe that discrimination has occurred. If there is a determination of probable cause, the complaint will proceed to a public hearing before an administrative judge.

The Division is committed to the efficient and effective investigation and adjudication of individual complaints of sexual harassment filed. In light of the powerful organizing that has laid bare the society-wide harm caused by sexual assault, DHR is seeing a dramatic rise in complainants coming forward. Since 2016, there has been a 62% increase in individual complaints of sexual harassment filed with DHR.

By taking effective action, DHR is able to bring justice on behalf of complainants who have faced such harassment. For example, in June 2017, DHR issued an order in a favor of three women from Western New York who faced sexual harassment at the dental office where they worked. The complainants were subjected to being called derogatory names, persistent invites to dates, inappropriate touching and other offensive behavior. When one of the complainants notified her manager of the unwanted sexual advances, the employer countered by saying that the aggressor "plays like that." The complainants were collectively awarded $152,880 in damages for emotional pain and suffering, unlawful retaliation and discrimination against them, and DHR issued a civil fine of $60,000 payable to the state for violating the law and required the respondents to provide

additional training. DHR's order was affirmed by the Fourth Department Appellate Division this past summer.

DIVISION OUTREACH, TRAINING, AND RECENT DEVELOPMENTS

The Division is also committed to ending sexual harassment and other forms of discrimination via outreach and education. In 2018 and early 2019, the Division participated in approximately 40 education and outreach presentations across the state that included discussion of preventing and addressing sexual harassment. Additionally, the Division held six (6) outreach events that specifically focused on sexual harassment, in Seneca Falls, Rochester, Cheektowaga, Newburgh, Buffalo and Long Island. DHR is currently planning a robust outreach and education campaign, which will include public events and an active social media presence focusing on all elements of the Law including protections against sexual harassment.

As part of last year's sexual harassment package, the New York State Labor Law now requires all employers in New York State to establish a sexual harassment policy and provide annual sexual harassment training. DHR was proud to work closely with the Department of Labor in developing a model policy, model complaint form and model training for employers to adopt in their workplaces, as well as an easily accessible website with guidance and resources for workers and employers on New York State's laws against workplace sexual harassment. Prior to being finalized, the models were presented to stakeholders and the public for public comment, and Department of Labor and DHR held meetings with employee and survivor groups, as well as business leaders and employers across the state. Hundreds of comments and suggestions were reviewed and taken into account before the final documents were released. The model policies and trainings are available online in readily accessible formats translated into eight languages. Both

the Department of Labor and DHR continue to engage in outreach and education on the state requirements, and we look forward to continuing those efforts as part of our upcoming outreach and education campaign.

Thank you for the opportunity to discuss the great work we do at DHR in our efforts to protect all New Yorkers from harassment and discrimination.

Central Office Address:
22 Reade Street
New York, NY 10007

Testimony of Dana Sussman
Deputy Commissioner, Intergovernmental Affairs and Policy
New York City Commission on Human Rights
Before the New York State Senate and New York State Assembly
May 24, 2019

Good morning Senators and Assembly Members. Thank you for convening today's joint hearing on the critical issue of combating sexual harassment in the workplace. I am Dana Sussman, Deputy Commissioner for Intergovernmental Affairs and Policy at the New York City Commission on Human Rights. I am pleased to be back before you after the first hearing on this topic in February. I want to thank you and the tireless advocates in the room today who have brought us together to continue this vital and overdue conversation.

In February, my testimony focused primarily on the ways in which the State Human Rights Law could be amended to align itself more closely with the New York City Human Rights Law, giving the state law more teeth to hold harassers and those that enable them accountable and to afford more victims the legal protections they need to pursue justice. My testimony identified four areas to strengthen the law: 1) correcting the decades of case law establishing the unnecessarily high "severe or pervasive" standard as the New York State legal standard for sexual harassment; 2) explicitly rejecting the *Faragher-Ellerth* affirmative defense; 3) making it possible for managers and supervisors, even if they do not have an ownership interest in the employer, to be held personally liable for sexual harassment; and 4) ensuring that punitive damages are available with respect to State Human Rights Law claims, as they are under other civil rights laws.

Today, I am here to briefly discuss the work of the Commission's Gender-Based Harassment Unit, and several recent developments in the Commission's efforts to combat sexual harassment in the workplace.

Gender-Based Harassment Unit

The Gender-Based Harassment Unit, which launched in January of this year, has a budget of $300,000. It has personnel lines for four dedicated staff members: a supervisor, two attorneys, and one non-attorney investigator. As soon as an individual with a workplace sexual harassment claim contacts the Commission through our general intake line or our webform, the Unit's supervisor is alerted, and will make a quick assessment as to whether there should be any immediate action taken. While most individuals who report workplace sexual harassment cases to the Commission come to us after they have left their place of employment, there are certain situations in which the Unit may be able to intervene early and quickly to descalate a situation or to prevent retaliation. In some circumstances, the Unit has been able to intervene immediately to ensure that evidence is preserved, such as surveillance video footage or documentary evidence, or to obtain an immediate transfer of a victim of harassment to ensure the victim is not interacting with the alleged harasser.

Not all circumstances warrant immediate intervention. For most cases, attorneys in the Unit will meet with the complainant within several weeks after the initial call or email, unless there is an urgent need to bring them in earlier, such as, for example, if a statute of limitations is about to run. The Unit's attorneys primarily focus on workers in low-wage industries, and while the Commission has cases of workplace sexual harassment spanning all industries in both high paying and low-wage work, the Unit has identified private security/building management and the hospitality industry, particularly the restaurant industry, as industries that represent a disproportionate amount of the Unit's cases. These industries highlight the vulnerabilities of workers who experience harassment, isolated and disconnected workplaces, and the lack of a clear or centralized management or reporting structure. The Gender-Based Harassment Unit also reports that, while most of the victims of cases at the Commission are women, they are seeing a significant number of men who are now reporting sexual harassment. The vast majority of alleged sexual harassers, although not all, are men, including in the cases in which men are the victims.

While the Unit's work is focused on investigating and prosecuting workplace sexual harassment claims, other attorneys in the agency's Law Enforcement Bureau also handle sexual harassment cases. There are simply too many for the Unit to handle alone. The Commission's case load of workplace gender discrimination cases that include a harassment claim doubled in a single year after Tarana Burke's #metoo movement relaunched in late 2017, from 56 in 2017 to 115 in 2018 (this number is slightly higher than the number I reported at the hearing in February because our figures then did not account for very late 2018 filed complaints). For the first four months of 2019, the Commission filed 42 additional complaints of workplace gender discrimination that include a harassment claim. As of April 30, 2019, the Commission is investigating 207 total cases of gender discrimination that include a harassment claim. That includes 13 matters in a pre-complaint posture, in which the Commission is seeking to resolve matters before a complaint is filed.

Recent Decision in *Automatic Meter Reading Corp. v. NYC Commission on Human Rights*

I also want to highlight a significant development since the hearing in February. In March of this year, the State Supreme Court, in *Automatic Meter Reading Corporation v. NYC Commission on Human Rights*, upheld a 2015 Commission Decision and Order in full in a workplace sexual harassment case. The Commissioner's Decision and Order was issued in late 2015, before the #metoo reawakening, which demonstrates the leadership of the Commission's long-standing recognition of the seriousness of these claims. The Commission ordered the highest ever civil penalty issued in Commission history and the highest available under the City Human Rights Law at $250,000 for willful, wanton, or malicious conduct, in addition to $422,000 in total damages to the Complainant, including back pay, front pay, interest, and $200,000 in emotional distress damages. The case involved a business owner who sexually harassed a female employee over a three-year period, repeatedly engaging in unwanted touching, regularly using lewd and sexually inappropriate language to and about her, and posting a sexually explicit cartoon in the workplace identified as the complainant.

The State Supreme Court's decision in March upholding the Commission's order is significant in that it upheld one of the highest damages awards and the highest civil penalty in Commission history, in a sexual harassment case, reaffirming that sexual harassment causes real emotional and mental trauma and devastating economic consequences to those that experience it. It affirmed the Commission's finding that the complainant was constructively discharged from her employment; that the sexual harassment made the workplace so unbearable that she had no other option but to leave. The state court decision further affirms that administrative agencies tasked with enforcing local anti-discrimination laws are entitled to deference in their decision-making and it sets a precedent for the issuance of the high damages and penalties where the evidence supports it.

Anti-Sexual Harassment Training

On April 1, the Commission launched its online, interactive, free anti-sexual harassment training. The training can be used to meet both the new City and State-mandated annual anti-sexual harassment training requirement. It is fully accessible to people with hearing and vision disabilities and mobility disabilities. It is available in Spanish with nine additional languages to come. It is optimized for smartphone use as well.

The training uses a story-based learning model, features scenarios drawn from real cases, and highlights the ways in which sexual harassment commonly intersects with other protected categories, including race, immigration status, national origin, religion, sexual orientation, gender identity, and pregnancy and lactation. It educates the user on the Commission's encompassing definition of gender, which includes gender identity and gender expression, and of its broad and protective sexual harassment standard. It also provides tools and strategies for bystanders to disrupt patterns of sexual harassment.

The training was developed with, and incorporates, feedback from over two dozen external stakeholders, including some of the stakeholders and advocates in this room today, several government partners from our sister agencies on the State level, and several dozen internal City agency and administration partners representing interests and expertise across City government.

And as of XXX, the training has been completed over XXXX times since we launched a month and a half ago. This does not reflect how many people have completed or viewed the training because multiple people, or entire workplaces, can view the training together, and that would only account for one training completion.

* * * * * * *

We are grateful to be here for the second hearing on workplace sexual harassment convened by the New York State Senate and Assembly this year. To the women, men, and non-binary people who have organized, spoken out, and demanded action, accountability, and system change, we, as government, are in your debt. Thank you.

Testimony of Michael Volforte
May 24, 2019

Good morning Chair Skoufis, Chair Biaggi, Chair Salazar, Chair Titus, Chair Crespo and Chair Walker and other members of the Senate and Assembly here today. My name is Michael Volforte and I am the Director of the Governor's Office of Employee Relations (GOER). Thank you for the opportunity to participate in this hearing on sexual harassment in the workplace.

In these remarks, I'd like to detail some of the very important steps we've taken under Governor Cuomo's leadership to tackle the issue of discrimination in the workplace. Shortly after the Governor was elected, we created a compilation of all of the rights and protections that Executive Branch State employees have from employment-based discrimination called Equal Employment Opportunity In New York State, Rights and Responsibilities: A Handbook for Employees of New York State Agencies (Handbook). The Handbook informs New York State employees of their rights and responsibilities when it comes to protecting employees from discrimination. In 2013, we implemented a standard investigation process for agencies to follow in the investigation of complaints of protected class employment discrimination. We also created a small unit within GOER to assist agencies in completing those investigations pursuant to that process and to provide technical guidance to both investigators and agency counsel alike. In 2013, we revised our Sexual Harassment Prevention training and mandated that all executive branch employees complete that training on a yearly basis. The next year we added two additional mandated annual training courses on all protected class employment rights and reasonable accommodation for both disability and religious reasons.

In August of 2018, we took another step forward in the investigation of complaints of employment-related protected class discrimination with the Governor's issuance of Executive Order 187. With the goals of achieving more independent investigations of employment discrimination complaints, but ensuring that the investigative body has the knowledge and understanding of the state workforce employer-employee relationship, Executive Order 187 transferred the responsibility for conducting investigations of all employment-related protected class discrimination complaints in agencies and departments over which the Governor has executive authority to the GOER. These investigations include discrimination complaints based

upon protected classes filed by employees, including contractors, interns and other persons engaged in employment at these agencies and departments. The protected classes are those set forth in applicable Federal and New York State law, Executive Orders and policies of the State of New York, including those based upon age, arrest/conviction record, color, creed, disability, domestic violence victim status, gender identity, marital/family status, military status, national origin, pre-disposing genetic characteristics, pregnancy related conditions, race, retaliation, sex, sexual orientation and sexual harassment.

Pursuant to Executive Order 187, effective December 1, 2018, all complaints of protected class employment-related discrimination are being investigated by GOER's Anti Discrimination Investigations Division (ADID). This responsibility covers approximately 130,000 executive branch employees but does not include employees of SUNY, CUNY, SED, the Legislature, Office of the Attorney General or the Office of the State Comptroller. GOER investigates complaints executive branch employees file internally within state agencies and external complaints (like those filed with the Division of Human Rights or the Equal Employment Opportunity Commission). Complainants may include employees, interns, contractors, delivery people, consultants – anyone whose workplace involves a state agency location or interaction with state employees consistent with State law and policy.

In preparation for its new responsibility, GOER received 41 Affirmative Action Administrators, called "AAOs" from state agencies who were already engaged in the investigation of employment discrimination complaints and hired another 6 employees to help manage its new staff. We also created an independent investigation process, developed a new complaint form entitled, "New York State Employee Discrimination Complaint Form," for employees to use and revised the Handbook, all the while making sure that our training, policy and procedures comport with the 2018 sexual harassment prevention laws that were enacted by the Legislature and signed into law by the Governor. Both the New York State Employee Discrimination Complaint Form and the Handbook are posted prominently on the GOER agency homepage and agencies have been instructed to regularly distribute them as well.

Individuals can now file complaints directly with GOER, without ever going through the chain of command at their employing agency. We've established an online fillable form that can be emailed directly to a dedicated email box. Employees can also mail complaints to GOER. We have AAOs located in a number of agencies and employees are free to speak to them and file complaints directly with them. We also mandate that any supervisor or manager who observes, witnesses or hears about discriminatory conduct, report the conduct by filing a discrimination complaint with GOER. Agencies send out reminders to their employees regularly to remind them to whom they can complain and where the form and policy on discrimination prevention is located.

GOER investigates complaints pursuant to our established 10 Step investigative process. Agencies must cooperate with GOER and provide GOER access to employees, information and documentation relevant to each complaint. When GOER receives a complaint, the complainant receives acknowledgment of receipt and agency general counsel is notified of the complaint as well. A respondent is notified at the point in the investigation when it is necessary to inform them or when interim administrative action is being taken. The parties are notified of the outcome when the investigation is concluded. Once a complaint is concluded, if it is substantiated, we work with the agency to ensure that they are implementing corrective or disciplinary action that we determine.

Confidentiality is important in our investigations. Complainants, respondents, witnesses and administrators at agencies are advised not to discuss complaints while the investigation is ongoing to prevent anyone from trying to influence the outcome and to avoid instances of retaliation. Of course, complainants and respondents, where represented are free to speak with their representatives. We are clear about prohibiting retaliation. Every employee, whether a witness, complainant or respondent is advised during the investigation process that retaliation is prohibited.

Statistically, we have seen a rise in the number of complaints overall. This is not unexpected and was anticipated given a number of factors, not the least of which is we are providing regular reminders of where employees can complain, and additionally, employees now have someone external to their agency to report discrimination to. This is consistent with what we are hearing anecdotally from other entities that handle complaints of discrimination—increasing awareness of what constitutes discrimination leads to more people filing complaints. Also, we determine whether the allegations in each complaint, if substantiated, violate the policies set forth in the Handbook, not whether they might actually violate the law. GOER investigates every allegation of discrimination, whether the complainant overheard a single sexual comment or joke to other far more involved and complex allegations of discrimination.

We take our role in investigating and resolving complaints of discrimination extremely seriously. No employee should have to endure harassment based upon their protected class status and we are committed to furthering efforts to both ensure that the State's policies concerning discrimination, harassment and discrimination in the workplace are followed and holding individuals accountable who violate our policies. Thank you for the opportunity to appear before you and I will answer any questions that you have.

Testimony of Noelle Damico
Senior Fellow, National Economic and Social Rights Initiative and
Secretary of the Board of the Fair Food Standards Council

Thank you for the opportunity to testify on behalf of the Fair Food Program that was created by the Coalition of Immokalee Workers, a farmworker-founded human rights organization that was awarded a Presidential medal in 2015, and to share the remarkable success of this Program's Worker-driven Social Responsibility paradigm in ending and preventing Gender-based Violence.

At a moment when our society is reckoning with sexual harassment as never before, with these hearings, the New York State Senate and Assembly have stepped forward to declare that our state is prepared to combat these abuses vigorously. The #MeToo movement has exposed the chronic infection of sexual harassment and assault in the workplace. What is now needed is an antibiotic capable of helping our body politic work together to create healthy, thriving workplaces. The good news is, we have the cure. And we know it works.

This cure of Worker-driven Social Responsibility emerged not from the Manhattan office of an NGO, but from the sweltering tomato fields of Immokalee Florida, from an approach developed by workers themselves – the true experts on human rights abuse in their workplace.

In the isolated, under-regulated environment of US agriculture, Gender-based Violence is severe and ubiquitous. As many as 80% of farmworker women surveyed, reported being sexually harassed or assaulted – that's 4 out of 5 women.[1] Earning low wages, fearing retaliation and facing barriers to filing legal complaints, many women elect to suffer abuse rather than report it and risk the consequences. As one woman put it: you allow it or they fire you. But that chilling reality began to change in 2011 with the advent of the Fair Food Program.

Through the Fair Food Program sexual assault has been virtually eliminated and sexual harassment has been dramatically reduced for 35,000 workers laboring on program farms in seven states stretching from Florida to New Jersey. Let me say that again. Cases of sexual harassment by supervisors *with physical contact of any kind* have been virtually eliminated and workers consistently report dramatic reductions in all forms of harassment. In US agriculture, a profoundly male-dominated industry notorious for sexual and economic exploitation, in *this* industry, the Fair Food Program has gotten to the point of prevention of sexual assault and harassment.

The story of the Fair Food Program begins with Immokalee farmworkers' determination to use market power of retailers at the top of the supply chain to realize their rights. The Coalition of Immokalee Workers united with tens of thousands of consumers of conscience to convince 14 brands including McDonald's, Aramark, and Walmart, to sign legally-binding agreements committing them to purchase only from growers who implement a farmworker-defined Code of Conduct with zero tolerance provisions for sexual assault and a range of other protections, including the right to work free of sexual harassment and to raise complaints without retaliation. Growers who fall out of compliance lose the ability to sell to all 14 of these massive brands.

---

[1] This CA Central Valley survey was cited by Human Rights Watch in "Cultivating Fear: The vulnerability of immigrant farmworkers in the US to sexual violence and sexual harassment," 2012.

Participating growers for their part commit to implement the Code, and to cooperate with the Program's monitoring organization. These legally-binding agreements form the backbone of the Fair Food Program which has generated a sea change in rights realization, leading Harvard Business Review to name the Fair Food Program "among the most important social impact stories of the last century."[2]

The Fair Food Program works because it is a system-level intervention that ends the imbalance of power between employers and workers that is at the root of sexual harassment, sexual assault and other abuses. In short, *it shifts the risk from the worker who reports sexual harassment to the employer who fails to address sexual harassment*. It put billions of dollars of purchasing power behind guaranteeing a workplace free of Gender-based Violence and other abuses.

What does this mean for workers? One worker put it simply: Now the fear is gone. A transgender worker spoke at length about the respect that she and others on her crew receive. A male worker who observed that, at so many farms, women risk losing their jobs if they speak out against harassment or reject the advances of a supervisor. He remarked how different the environment is at FFP farms. He added that, as a man, he believes that a more respectful work environment benefits him as well, and he is very relieved to work in a place where women are not treated poorly.[3]

Because of the Fair Food Program's phenomenal success in addressing sexual harassment and assault, the Equal Employment Opportunity Commission's Select Taskforce singled out the Fair Food Program calling it a "radically different accountability mechanism" and adopted many of those mechanisms as core recommendations in its landmark 2016 report.[4]

The Fair Food Program's ground-breaking approach was distilled by CIW into a new paradigm called Worker-driven Social Responsibility, that is translating and adapting core rights mechanisms successfully in other industries. WSR was strengthened through the design and implementation of the Accord on Fire and Building Safety in Bangladesh demonstrating the paradigm's exponential potential for realizing human rights for millions of workers. In Vermont, Migrant Justice has adapted the WSR model to the dairy industry through the Milk With Dignity Program where it has proved singularly successful in combatting sexual violence among a largely immigrant workforce on isolated dairy farms. Construction workers in Minneapolis are poised to launch their own WSR program, as are female garment workers in the southern African country of Lesotho. And in New York, the Model Alliance is adapting WSR to create a truly inclusive, safe and fair place to work through their RESPECT Program. As the magazine Civil Eats recently said, "It's a template that when you adjust it, can be applied to almost any work situation."[5] And indeed, that's just what's happening. In response to the hearing's request for strategies to combat sexual harassment, here are a few lessons from our experience that can be put to work elsewhere.

---

[2] Audacious Philanthropy, Susan Wolf Ditkoff and Abe Grindle, Harvard Business Review, Sept./Oct. 2017.
[3] Fair Food Program 2017 Annual Report, page 51. Available at http://fairfoodprogram.org
[4] http://ciw-online.org/blog/2016/07/eeoc-singles-out-fair-food-program/ and https://www.eeoc.gov/eeoc/task_force/harassment/report.cfm (accessed May 20, 2019)
[5] "Florida Farmworkers Take Their Fight to Park Avenue," by Lisa Held, Civil/Eats, March 2018,

Redress the imbalance of power through legally binding agreements with consequences
Whether in a government office or a factory floor, change does not come from voluntary good will but from binding agreements with serious consequences for refusing to address sexual harassment or assault.

Provide worker-to-worker training in rights and the ability to report without fear of retaliation
Sexual assault and harassment are crimes of power *and* opportunity. Trained in their rights, equipped with the ability to report problems through multiple channels -- including a 24 x 7 confidential hotline -- and protected from retaliation, thousands of farmworkers have become front-line of monitors of their own rights leaving bad actors nowhere to commit their crimes. Workers in other workplaces can be similarly empowered and protected.

Monitor conditions; swiftly investigate; require and assist compliance; report findings
The Fair Food Standards Council, which oversees the Fair Food Program, undertakes deep-dive audits (interviewing 50-100 percent of workers on farms).[6] FFSC investigators also staff the 24 x 7 complaint hotline in Spanish, English, and Creole. Upon receipt of a complaint, they immediately open an investigation. Almost 80 percent of all complaints are resolved in one month; 50 percent within two weeks. The FFSC is empowered to render judgements on compliance and design resolutions. They provide assistance to help farm employers thoroughly address problems so that they don't arise in future. FFSC updates its website regularly to reflect current compliance by participating growers and publishes reports providing maximum transparency.

Set serious consequences for perpetrators and employers who fail to remedy and prevent
Since the Program's inception, 42 supervisors have been disciplined for sexual harassment and 11 of those supervisors have been terminated and are therefore no longer able to work on FFP farms in any state. The removal of notorious supervisors who preyed on women increased worker confidence in the confidential complaint system. The Program also requires field supervisors who witness sexual abuse to intervene and report or else face disciplinary action.[7] Any employer that refuses to terminate an employee confirmed by FFSC to have committed sexual harassment with physical contact of any kind will be suspended. People will trust compliance systems when they see them working.

As the NYS Senate and Assembly consider legislation to address sexual harassment in government offices, I hope that you will also consider the important role government can play in ending and preventing gender-based violence in the workplace by encouraging private sector uptake of WSR by employers and in corporate supply chains as well as adopting WSR for government procurement. With your commitment, we will surely step closer to the day when all workers will labor in respectful and dignified workplaces. Thank you.

---

[6] Since 2011, the FFSC has interviewed over 23,630 workers face-to-face. Fair Food Program 2018 Update, page 14.
[7] Fair Food Program 2018 Update, page 24. Forthcoming from the Fair Food Standards Council.

Testimony by Sara Ziff, Executive Director of the Model Alliance:

Public Hearing on Sexual Harassment in the Workplace

May 23, 2019

Sara Ziff
Founding Director, Model Alliance
302 A West 12th Street, Suite 136
New York, NY 10014

Dear New York State Committee Members:

Thank you for hosting this hearing and for giving me the opportunity to testify today. My name is Sara Ziff and I am the founder and executive director of the Model Alliance, a nonprofit research, policy, and advocacy organization that advances fair treatment and equal opportunity in the fashion industry.

Too often, models are treated as objects, and not as legitimate members of the workforce who deserve to work with the same dignity, respect, and basic legal protections other workers enjoy under New York State's sexual harassment and employment laws. Notwithstanding the success I have had as a model for the last twenty years, many of my peers and I have experienced inappropriate demands, including routinely being put on the spot to pose nude and provide sexual favors. In some cases, modeling agencies are sending models to known predators and putting them in compromising situations that no person, and especially no child, should have to deal with.

Essentially all professional models operate under fixed-term, exclusive contracts to their agencies, who exert a great deal of control over their working lives. The agencies then contract with a client – a brand, magazine, department store and the like – for the model's work. If a model is harassed in the workplace, to whom can she turn? The agency, who will blame the client for the unsafe workplace? The client, who will say they have no contractual relationship with the model? For models and other independent contractors in this type of triangular relationship, there is still no clear remedy.

Moreover, most modeling agencies assert that they are not regulated by New York State laws governing employment agencies, which would subject them to the necessary licensing and regulation. Even though the primary purpose of modeling

agencies is to obtain employment for their models, they claim such activities are "incidental" to the general career guidance they provide as "management companies"—and therefore are not subject to the state's regulation. I believe this is an issue that should be examined by the New York State Department of Labor.

Two years ago, I brought these concerns to Assemblywoman Nily Rozic. I had done a research project with the legal clinic at Fordham Law School on the working conditions of models, and when it came to sexual harassment, the law professors said they were all mortified by what they found, and surprised by the limited scope of the law.

The Model Alliance has since worked with Assemblywoman Rozic to introduce the Models' Harassment Protection Act. If enacted, it would extend certain protection to models, putting designers, photographers and retailers (among others) on notice that they would be liable for abuses experienced on their watch. The bill would amend the current law to explicitly include models, explicitly forbid sexual advances and commentary or other forms of discrimination linked to their employment, and would require clients to provide models upon booking with a contact and avenue for filing any complaints.

Models in New York State need specific provisions because of their convoluted employment chain. Modeling agencies in New York argue that models are independent contractors, not employees. The agencies also claim to act merely in an advisory capacity by claiming that their role of booking jobs for the models they represent is incidental to their primary role of providing advice. When a client books a model through an agency, the model has no direct contract describing the scope of her work for the client.

Models have fallen through holes in the existing statutory safety net, including the "incidental booking exception clause." That means that until now, in New York, which is regarded as the heart of the American modeling industry, it has been unclear where legal liability for job-related sexual harassment lies.

There has been too long a history of institutional acceptance – or at a minimum, recklessly ignoring– sexual harassment by both agencies and clients. Models should have the same recourse as all other employees to sue employers. They should have a direct mechanism for making complaints and should be assured that courts are willing and able to hold the agency and the client – their joint employers – responsible for the abuses they suffered. Regardless of how models are classified, it is imperative that they have an enforceable right to work in a safe and fair environment.

New York State can remedy these shortcomings by passing the Models' Harassment Protection Act. The perceived glamour of the industry and gaps in the law should no longer be used to deny models a safe workplace or appropriate recourse if abuse occurs. We deserve no less than any other segment of New York's workforce.

Remarks to the New York State Senate and Assembly joint public hearing on Sexual Harassment in the Workplace
Friday, May 24, 2019
By Marissa Hoechstetter

Thank you for the opportunity to address you today about how the lack of oversight of physicians and other licensed medical professionals puts employees and patients in danger. I chose to testify because, while the hospital and clinics where I was sexually assaulted were not my workplace, they are someone's workplace. No hospital or doctor's office--no workplace--should ever put their reputation and profit ahead of their patients' safety. Real improvements must be made so that workers and patients, particularly the most vulnerable among us, are not needlessly and repeatedly exposed to sexual harassment and assault.

Most doctors are well intentioned, caring people dedicated to their field. But, the minute you walk into a doctor's office, they have power over you. There are often legitimate reasons for a doctor's hands to be on or in your body. It is a unique profession and those who abuse this do not deserve protection.

As a patient at Columbia University and New York-Presbyterian Hospital from 2009 to 2012 my OB/GYN, Robert Hadden, performed overly touchy exams, made inappropriate comments about my body, examined me without nurses in the room, and on my last visit with him, undoubtedly sexually assaulted me. When I realized what was happening, I never went back. The assaults and the experience of coming forward have fundamentally changed my life. I know now that what happened to me was allowed to transpire because of a lack of action by his employers and a lack of oversight by regulators. For over 20 years, this predator retained power over patients and staff and used that for sexual gratification.

Despite more than 20 women reporting to the police and the Manhattan District Attorney, Hadden ultimately only pled guilty to crimes against just one victim. Two minor counts culled down from a long list — a list that would have been longer had the DA included me and others in the case. Nurses who worked with him claim to have reported his behavior to supervisors going back decades. His employers have yet to take any responsibility and victims continue to come forward. There are probably hundreds or even thousands of others out there. It's a sickening list: some of us were pregnant (like I was); some were minors (including one Hadden himself had delivered); and some had their newborn babies in the room with them. His own defense attorney said during the criminal trial that Hadden had over 30,000 patient visits.

A recent study found that most sexual misconduct by doctors involved a combination of important factors: 100% of the perpetrators were male and 85% of them always examined patients alone. 96% of known cases involved repeat offenses and the abuse was often accompanied by milder—more visible— behaviors such as comments and touching over 90% of

the time.[1] Yet, these same researchers wrote, "It is not possible to provide an accurate estimation of the frequency of sexual violations in medicine. Most patient-victims do not report sexual violations; one study estimated that fewer than 1 in 10 victims come forward. This is significantly lower than the overall rate of 36% of cases of rape or sexual assault in the United States reported to police by female victims."

When that information is paired with a National Academies of Sciences, Engineering and Medicine report that says that up to half of medical students have experienced some form of sexual harassment[2] and another study published in the Annals for Internal Medicine that up to 70 percent of female physicians have reported sexual harassment,[3] it becomes clear that healthcare has a sexual harassment and sexual assault problem.

It took some time before I realized there was a state office charged with investigating complaints about physicians. In New York, the education department issues licenses to practice medicine. Discipline is split between two offices under the Department of Health: the Office of Professional Medical Conduct (OPMC), which investigates reports of incompetent or unethical doctors, and the Board for Professional Medical Conduct (BPMC), which adjudicates those cases and decides on punishments. This is not just a few people in a back room somewhere, this is a whole system -- staff, investigators, board members, administrative law judges reviewing cases -- all using taxpayer funds with a mission to protect the public.

New York is one of only six states that does not conduct a background check as a requirement of initial licensure for medical professionals.[4] This might make New York attractive for those with a criminal record to seek licensure here. The National Practitioner Data Bank, a resource available only to state boards, was established by Congress in 1986 to prevent practitioners from moving state to state without disclosure or discovery of previous damaging performance. A survey of Data Bank users found that about 21% of matched query responses contained new information. In other words, when states reviewed a doctor's application for licensure, they found new information that had not been self-reported on applications almost a quarter of the time. If New York doesn't conduct background checks and doesn't sufficiently query the Data Bank, we are letting physicians get away with lies and omissions and are putting the public at risk.

In 2014, the New York Public Interest Research Group found that over 77% of doctors sanctioned for negligence by OPMC were allowed to continue to practice. Nearly 60% of the actions against doctors were "based on sanctions by other states, the federal government, or the courts, not directly as the result of an OPMC-initiated investigation."[5] One example of this was Hadden surrendering his license to the state as a condition of his plea. OMPC had nothing

---

[1] https://journals.sagepub.com/doi/full/10.1177/1079063217712217
[2] https://www.nap.edu/catalog/24994/sexual-harassment-of-women-climate-culture-and-consequences-in-academic
[3] https://www.ncbi.nlm.nih.gov/pubmed/10836916
[4] http://www.fsmb.org/siteassets/advocacy/key-issues/criminal-background-checks-by-state2.pdf
[5] https://www.nypirg.org/health/questionabledocs/Questionable_Doctors2014.pdf

to do with his loss of license and because of a lack of transparency, there is no way to know if he had been previously reported or disciplined.

In New York, staff and peers are required to report to the OPMC any information that reasonably appears to show that a doctor is guilty of alleged professional misconduct within 30 days. Hospitals also are required to report when a doctor's clinical privileges have been curtailed or when a doctor resigns to avoid discipline. But, there is no penalty for not doing so and there is no way to know if they're following the law. California, for example, issues fines for those who do not report. Columbia and New York-Presbyterian had plenty of notice but it does not appear that they ever reported Hadden to OPMC. Does anyone really think a hospital will raise it's hand and self-report that they're employing a sexual criminal?

Because I speak publicly about my assault, victims regularly contact me seeking help and most have never even heard of OPMC. I have spoken with legislators and staff who do not understand the complexities and nuances of this system. I have spoken with OPMC staff who do not understand or could not clearly communicate what is in their jurisdiction. I specifically asked if sexual harassment of a hospital staff member by a doctor was reportable. I was told that "it depends" and people should report the harassment so that OPMC can review the complaint and determine if it is in their jurisdiction or not. How can we expect patients or employees to know what and where to report when we're not clear about whose responsibility it is to investigate and discipline?

There is actually no time limit on being able to seek justice from the OPMC for a doctor who abused or sexually harassed you. They are required to investigate all complaints regardless of when they occurred. We encourage victims to speak up but when they do, they are often met with a justice system that doesn't offer much relief (or justice, as I've learned). In addition to mustering the courage to come forward, we must overcome mountains of disbelief, inertia, and prosecutorial discretion. Despite OPMC's flaws, the public should be aware of this office as a resource, especially when other criminal justice systems are likely to let us down.

Last year, the Village Voice reported on an osteopathic doctor from Great Neck who admitted to verbally harassing a patient and sending her inappropriate text messages. He was fined $10,000 and required to be chaperoned any time he saw a female patient. He then broke that rule two years later yet his license is still active.[6]

Imagine that you live in Great Neck and want osteopathic care. On paper there are two doctors who look exactly the same except that one is accompanied by an extra staff person (the chaperone). Which one would you choose? Remember, you don't know why this extra staff person is in the room.

Time and again, we see abuse happen even when others are present (think of the Nassar cases). In addition to putting a patient in a vulnerable position with a previously abusive doctor,

[6] https://www.villagevoice.com/2018/03/29/new-york-allowed-a-sexual-predator-to-practice-medicine-for-decades/

the chaperone, who themselves has an employer/employee relationship with the doctor, has to work in a toxic environment. Boards are knowingly putting criminals back into private situations with their previous victims. Think of what we now know about the Catholic church, where clergy with credible allegations of abuse were simply moved to new environments to supposedly perform differently under new supervision. The public just doesn't know enough about the practice of chaperones in medicine to be outraged, but they should be.

Patients and medical staff who would visit or work with a doctor have a right to know their full disciplinary history. California recently became the first state to require that doctors notify their patients if they are on probation by the Medical Board of California for wrongdoing, including sexual misconduct.[7] Other states are following suit. The "Patient's Right to Know Act" was an important step towards transparency. It also puts the onus to inform the public on the provider and the state board not on the victim. A 2016 Consumer Reports survey showed that 82% of Americans favor the idea of doctors having to tell patients they are on probation, and why.[8]

Doctor's offices should be required to post signage about patients' rights promoting OPMC's website as a resource. We know that victims turn to the internet privately seeking information about sex crimes, statutes, and reporting or support resources. OPMC must also update it's website -- the word sex only appears in one buried place and there is nothing that explicitly mentions sexual harassment or assault as professional misconduct within their purview.

The site does offer a link to relevant state laws, which could potentially offer more clarity for those who can understand them. Under relevant Education law, Article 131-A, which offers a definition of professional misconduct applicable to physicians, the word sex only appears in relation to a definition of misconduct under the field of psychiatry. Item #31 does state that professional misconduct can be "Willfully harassing, abusing, or intimidating a patient either physically or verbally."[9] Under Section 230 of Public Health Law which explains the penalties for misconduct and proceedings for the OPMC, neither the word sex or harassment appear anywhere. The word abuse appears only in relation to drug and alcohol abuse.[10] The relevant laws should clearly state sexual harassment and sexual abuse as crimes that are considered professional misconduct for physicians.

I hope that my remarks today help shed light on sexual harassment and sexual assault in medicine. Doctors are an important part of our lives and have specialized knowledge that we rely on to be happy, healthy, and productive. But, they are not gods who deserve to be protected at the public's expense. There is a lot more I could say but for now I will share that it is my hope that the state resources set up to protect us can, at a minimum, be made more visible and accessible; that their role in curbing these crimes can be clarified, and that we can work together to support victims. Thank you.

---

[7] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1448

[8] https://www.consumerreports.org/media-room/press-releases/2016/03/consumer-reports-finds-its-too-difficult-for-patients-to-learn-about-physicians-disciplinary-records/

[9] https://www.health.ny.gov/regulations/education_law/article/131-a/docs/131a.pdf

[10] https://www.health.ny.gov/regulations/public_health_law/section/230/docs/230.pdf

Attachments:
"Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group"
https://www.jmronline.org/doi/pdf/10.30770/2572-1852-104.4.23

"Time to End Physician Sexual Abuse of Patients: Calling the U.S. Medical Community to Action"
https://link.springer.com/article/10.1007%2Fs11606-019-05014-6

"Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6031470/

"Questionable Doctors"
https://www.nypirg.org/health/questionabledocs/Questionable_Doctors2014.pdf

For Review:
Atlanta-Journal Constitution's "Doctors & Sex Abuse" series
http://doctors.ajc.com/

Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group

James M. DuBois, DSc, PhD; Emily A. Anderson, MPH, PhD; John T. Chibnall, PhD; Leanne Diakov, JD; David J. Doukas, MD; Eric S. Holmboe, MD; Heidi M. Koenig, MD; Joan H. Krause, JD; Gianna McMillan, MA; Marc Mendelsohn, MD; Jessica Mozersky, PhD, MBE; William A. Norcross, MD; Alison J. Whelan, MD

ABSTRACT: This article reports the consensus recommendations of a working group that was convened at the end of a four-year research project funded by the National Institutes of Health that examined 280 cases of egregious ethical violations in medical practice. The group reviewed data from the parent project, as well as other research on sexual abuse of patients, criminal prescribing of controlled substances, and unnecessary invasive procedures that were prosecuted as fraud. The working group embraced the goals of making such violations significantly less frequent and, when they do occur, identifying them sooner and taking necessary steps to ensure they are not repeated. Following review of data and previously published recommendations, the working group developed 10 recommendations that provide a starting point to meet these goals. Recommendations address leadership, oversight, tracking, disciplinary actions, education of patients, partnerships with law enforcement, further research and related matters. The working group recognized the need for further refinement of the recommendations to ensure feasibility and appropriate balance between protection of patients and fairness to physicians. While full implementation of appropriate measures will require time and study, we believe it is urgent to take visible actions to acknowledge and address the problem at hand.

Introduction

This article reports on the recommendations developed by a multidisciplinary working group that was convened to address the problem of egregious ethical violations in medicine. By egregious violations, we mean clear violations of codes of medical ethics and law that directly harm patients. The working group meeting followed four years of research on cases of violations led by a team at Washington University School of Medicine (WUSM) with funding from the National Institute of Aging (NIA). Detailed methods and findings from the background studies are reported elsewhere.[1-3]

Background

Codes of medical ethics and professionalism commit physicians to acting in accord with core values of medicine, including care for patients, altruism, competence, compassion, and respect for patient autonomy.[4,5] Such values support the relationships needed to meet the goals of medicine — healing, prevention of disease, and palliation of pain and suffering.[6] While it is challenging to live up to these ethical ideals in all patient encounters,[7] egregious ethical violations appear to be relatively rare. Such violations are naturally hidden events. When they become apparent, disciplinary actions provide some of the most trustworthy prevalence data: approximately five in 1,000 physicians are disciplined by a state medical board per year, and only 1.1 in 1,000 receives severe disciplinary action involving license revocation, suspension or surrender.[8-10]

While rare, the rate of severe disciplinary actions against physicians is nevertheless similar to the rate of new diagnoses of breast cancer each year

CODES OF MEDICAL ETHICS AND PROFESSIONALISM COMMIT PHYSICIANS TO ACTING IN ACCORD WITH CORE VALUES OF MEDICINE, INCLUDING CARE FOR PATIENTS, ALTRUISM, COMPETENCE, COMPASSION, AND RESPECT FOR PATIENT AUTONOMY.

(1.3 in 1,000) and much more common than new diagnoses of HIV (0.14 in 1,000) — both of which are widely recognized as urgent challenges for medicine and public health.[11] Moreover, most egregious

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

violations are never reported to state medical boards,[2,3,12,13] and when they are reported, some boards infrequently take action against a physician's license.[9,14] Thus, such violations — while uncommon — are undoubtedly far more prevalent than current databases such as the National Practitioners Database (NPDB) indicate.

As noted, the working group was particularly concerned with a subset of the causes of disciplinary action by boards: egregious violations of medical ethics such as sexual abuse of patients, criminal or negligent prescribing of opioids, or performing unnecessary surgeries for profit.[15] The WUSM team focused on these three behaviors because they not only contradict the core values of medicine, but also directly harm patients. Additionally, prior research by the team indicated that these forms of wrongdoing were sufficiently frequent to accrue at least 75 cases in each area of wrongdoing, which was necessary for purposes of statistical modeling.[16]

The recent case of Larry Nassar, a physician who practiced sports medicine, illustrates many of the dynamics commonly found by the WUSM research team in such cases. Across more than 20 years, Nassar sexually molested more than 265 girls (as young as six years of age) and young adult women.[17-19] In a lawsuit filed in April 2017, a woman claimed that Nassar had sexually assaulted her while he was still in medical school in 1992.[17] Additionally, he was convicted of receiving and possessing child pornography[20] and charged with practicing without a license in Texas[21] and obstruction-of-justice for destroying and concealing evidence.[20] While Nassar completed a residency and fellowship, we found no evidence that he was board certified.[18] It has been reported that he was almost dismissed from medical school after two semesters because he failed biochemistry twice.[22] In at least eight instances, his victims reported his behavior to someone in leadership, who failed to report the behavior to the state medical board.[18] When law enforcement was first notified, Nassar managed to distort his actions and present them as within the standard of care. No witnesses were involved to dispute his claims.[18] In repeated instances, Nassar sexually assaulted his victims when their parents were in the room, demonstrating not only his boldness but also the trust that patients and others have that a physician will only perform medically-appropriate actions according to the standard of care.[20]

WITHIN THE CURRENT SOCIAL CLIMATE IN THE UNITED STATES, CHARACTERIZED BY A GROWING AWARENESS AND INTOLERANCE OF SEXUAL HARASSMENT, IT IS PARTICULARLY APPROPRIATE FOR THE FIELD OF MEDICINE TO TAKE ACTIONS TO IDENTIFY, APPROPRIATELY RESPOND TO, AND PREVENT SUCH EGREGIOUS VIOLATIONS OF MEDICAL ETHICS.

The recent extended investigative report "Doctors and Sex Abuse" by the *Atlanta Journal-Constitution* illustrates the damage that such violations pose to the reputation of medicine, particularly when ongoing abuse is permitted to continue through oversight failures.[13,23-25] Within the current social climate in the United States, characterized by a growing awareness and intolerance of sexual harassment, it is particularly appropriate for the field of medicine to take actions to identify, appropriately respond to, and prevent such egregious violations of medical ethics. However, we believe it is most appropriate to view the problem of sexual abuse of patients as one species within a larger genus: egregious ethical violations that directly harm patients. Prescribing opioids for profit to those with known substance user disorders[26-28] or performing unnecessary invasive procedures for profit, such as spinal fusion surgeries or cardiac catheterizations,[29-31] cause patients psychological, physical, and financial harm, and in some cases death.[32]

...WE BELIEVE IT IS MOST APPROPRIATE TO VIEW THE PROBLEM OF SEXUAL ABUSE OF PATIENTS AS ONE SPECIES WITHIN A LARGER GENUS: EGREGIOUS ETHICAL VIOLATIONS THAT DIRECTLY HARM PATIENTS.

Many features of the Nassar case are common across different kinds of egregious ethical violations: The violations were committed by a male, repeated, and selfishly motivated; oversight was lax or absent; and individuals who learned about the violations failed to take decisive action.[1-3,33] Accordingly, many of the actions that need to be taken to identify cases sooner and respond decisively are the same across different kinds of violations.

To address this matter, the authors convened as a working group on October 2 and 3, 2017.

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

The working group consisted of four PhD-level investigators from the research team with backgrounds in social science research and bioethics, and nine external experts. Experts included a patient advocate, a health lawyer, legal counsel for a state medical board, and physicians from the Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education, American Medical Association Council on Ethical and Judicial Affairs, the Federation of State Medical Board's (FSMB) *Journal of Medical Regulation*, the Academy for Professionalism in Health Care, and the Physician Assessment and Clinical Education Program. All members agreed that they did not speak on behalf of any institutions or programs. However, members were selected in light of their expertise, which often derived from relevant experience in such settings.

Prior to convening the working group meeting, WUSM research team members conducted a systematic review of the literature on legal and disciplinary actions in medicine. Structured search terms were developed with research librarians from the Washington University Schools of Law and Medicine. Searches were conducted using Lexis-Nexis and PubMed from 2007 onwards. The team examined 2,386 records from Lexis-Nexis and 5,176 records from PubMed. Relevant papers were summarized for working group members in three categories: empirical studies, recommendations from legal scholars, and general background information.

The working group meeting opened with four sessions: a general overview of disciplinary actions, and three sessions on specific forms of violations — namely, sexual abuse of patients, negligent or criminal prescribing of opioids, and the performance of unnecessary (fraudulent) invasive procedures. Two subgroups were formed: one focused on education and remediation, and one focused on policy and oversight. Each session adopted a similar format:

- Presentation of data from the literature review and the WUSM study team's project
- Subgroup evaluation of recommendations offered in the published literature and generation of new recommendations
- Plenary discussion of all recommendations

Recommendations were then revised based on plenary group discussions and post-meeting review of a draft document.

The group set the goals of offering recommendations that would prevent the majority of instances of egregious ethical violations and, when such violations did occur, help oversight programs to identify them sooner and take the steps necessary to ensure they are not repeated. The consensus of the group was that each of the recommendations offered is worth pursuing. By "pursuing" we mean there is reason to believe a recommendation will be effective in fostering the goals of the project, while recognizing that any recommendation will require closer examination and adaptation by policymakers and stakeholders to ensure that they are feasible and balance obligations. To use an analogy from architecture, we offer a schematic design rather than a blueprint with technical specifications.

> PRIOR TO CONVENING THE WORKING GROUP MEETING, WUSM RESEARCH TEAM MEMBERS CONDUCTED A SYSTEMATIC REVIEW OF THE LITERATURE ON LEGAL AND DISCIPLINARY ACTIONS IN MEDICINE.

Recommendations

We recommend pursuing the following actions to prevent and appropriately respond to egregious ethical violations in medicine.

1. Recruit Trainees, Physicians and Staff Who Embrace the Positive, Core Values of Medicine

Medical schools and medical centers must seek trainees at all levels (medical students, residents, fellows), attending physicians, and staff who demonstrate a commitment to core values in medicine such as caring for persons, altruism, competence, compassion, and respect for patient autonomy. It is controversial and of questionable efficacy to prospectively screen medical students, residents, fellows and staff using personality testing aimed at identifying deficits. Focusing on commitment to positive values may be more fruitful in advancing the mission of medicine.[34-37] A growing body of literature has defined the positive values and traits associated with medical professionalism.[7,38-40] While assessment lags behind, there is a consensus that assessing professionalism requires a multi-model approach,[41] which might include the use of standardized patients,[42]

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

validated tests using realistic vignettes,[43] multi-source or 360° surveys,[44] or direct observation of behaviors.[45]

2. Educate Leaders to Create a Culture of Professional Integrity

Many of the problems observed in medicine are reflected within the broader cultures in which physicians work. Changing national and institutional cultures in ways that demonstrate respect for all persons will support professional behavior.[41] Leaders need to be particularly sensitive to their role in enforcing policies and supporting interventions to end serious wrongdoing by physicians. Far too often, cases of egregious ethical violations are ignored, covered up or even enabled by leaders. To combat problems of cynicism and inaction, medical students, residents, nurses and others who are often in the best position to observe and report wrongdoing must be empowered to do so. Further, as they may feel particularly vulnerable to retaliation, they must be protected. A culture of professional integrity can protect patients and whistleblowers more than current laws.[46,47] To accomplish this goal, leaders must investigate credible complaints in a timely manner that balances concerns for privacy with the need for transparency. Leaders must not tolerate behavior that threatens patient safety or creates a hostile workplace.[48] Leaders in medicine must be selected for their character, experience, and abilities, and be provided with formal training to ensure that they have the skills needed to lead effectively with integrity.[49,50] We recommend that leadership programs for physicians incorporate sessions focused on rationales and strategies for responding effectively to allegations of egregious wrongdoing. These sessions might be led by individuals with expertise in organizational psychology and human resources.

3. Provide Feedback to Physicians

Studies indicate that physicians often make positive changes to behavior when provided with objective data comparing them to peers[51-55] or with 360° (multisource) feedback from diverse colleagues.[56] The following three examples illustrate ways of providing feedback from diverse stakeholders. First, institutions can conduct physician evaluations using multisource feedback from a large number of individuals, including patients, caregivers, family members, supervisors, physician peers, allied health co-workers, and trainees. Such feedback can support positive behavior change while protecting evaluator identities. Second, prescription drug monitoring programs (PDMPs) can be used not only to track patterns of "drug-seeking patients" but also to provide feedback to physicians on their prescribing patterns vis-à-vis peers within their specialty. Third, medical consultants can be encouraged to

> TO COMBAT PROBLEMS OF CYNICISM AND INACTION, MEDICAL STUDENTS, RESIDENTS, NURSES AND OTHERS WHO ARE OFTEN IN THE BEST POSITION TO OBSERVE AND REPORT WRONGDOING MUST BE EMPOWERED TO DO SO.

provide feedback to referring physicians and vice versa. This would increase the perception of peer oversight, which may also be protective against egregious ethical violations.[2]

4. Increase Oversight by Physician Peers and Colleagues

Oversight may include feedback, but implies a more systematic approach to observation, including establishing a sense of being observed. Some data indicate that peer oversight and group practices may be protective against serious practice violations.[57-60] We offer three examples of the kind of oversight that could be provided more consistently by building on existing systems. First, medical societies can require peer review of cases involving invasive or risky procedures. We recommend that all persons who conduct risky invasive procedures participate in registries sponsored by medical societies. Second, many settings, such as solo medical practices, make ongoing peer-review by highly qualified physicians difficult. However, by utilizing electronic medical records it is possible to provide peer review at a distance. Peer reviewers might be incentivized by offering CME credits for participating in auditing processes. Third, chaperones should be provided by default when an intimate examination is medically indicated. Chaperones should be absent only at a patient's request. These requirements must be enforced.[1,61] In some cases, following harmful deviations from standards of care, we recommend that physicians lose the right to practice in the absence of peers.

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

5. ***Track Wrongdoing and Consequences***

Tracking wrongdoing is essential to protecting patients by providing data to inform decisions of disciplinary committees, patients who seek information on their physicians, and researchers who seek to understand professional violations. Tracking consequences enables transparent evaluation by state medical boards and other disciplinary bodies. Several steps can be taken to improve the quality of tracking. We recommend that the NPDB guidelines require that state medical boards and reporting institutions provide descriptions of the facts of a case, thus enabling trained NPDB staff to code appropriately. Appropriate coding will avoid the use of uninformative categories such as "other" and "not applicable"—the most common codes used at present, when codes are assigned.[9,62] To permit identification of links between specific forms of wrongdoing and the disciplinary actions taken, we recommend connecting NPDB data to state medical board data.[63]

We recommend the creation of a national tracking system to track serious disciplinary actions against individuals through medical school, graduate medical education, and medical practice to facilitate rapid response to wrongdoing. Such a database—because it might track more minor violations and even accusations—might be highly confidential and accessible only to those who are investigating or adjudicating cases. Negligent reporting, credentialing, privileging and failure to report physicians under disciplinary scrutiny by institutions should be recognized as causes of action when patients are unnecessarily harmed by a physician with a history of professional violations.[64] Institutions should be protected from legal liability when sharing information in good faith with other institutions regarding a physician's past performance. We encourage establishing a system whereby private insurers could share with the Centers for Medicare and Medicaid Services information about physician billing patterns to enable earlier detection of fraudulent or illegal behaviors by expanding the pool of available data.[65,66] Either a national PDMP should be established or states must be able to query neighboring states' PDMPs without increasing the administrative burden (e.g., by using a single log-in portal).

WE RECOMMEND THE CREATION OF A NATIONAL TRACKING SYSTEM TO TRACK SERIOUS DISCIPLINARY ACTIONS AGAINST INDIVIDUALS THROUGH MEDICAL SCHOOL, GRADUATE MEDICAL EDUCATION, AND MEDICAL PRACTICE TO FACILITATE RAPID RESPONSE TO WRONGDOING.

6. ***Foster the Establishment of More Uniform and Transparent Actions by State Medical Boards***

Currently, tremendous variation exists in how state medical boards respond to instances of serious wrongdoing.[9,14] In some states, physicians commonly return to practice following severe disciplinary action for egregious professional violations.[9,15,24,67-70] We encourage the FSMB to provide leadership by sharing best practices across state medical boards and publishing examples of sensible and effective model statutes. We recommend that boards publish their disciplinary actions on publicly available websites. While some boards do this already, many do not, or the data they publish are vague and incomplete.[71]

FROM THE FIRST DAY OF MEDICAL SCHOOL THROUGH MEDICAL PRACTICE, PATTERNS OF BEHAVIOR THAT RUN CONTRARY TO THE GOALS OF MEDICINE SHOULD BE MONITORED AND TREATED IN THE SAME MANNER AS GROSS INCOMPETENCE.

7. ***Across All Career Stages, Permanently Remove Individuals from Medicine Following Egregious Violations or a Persistent Failure to Serve the Goals of Medicine***

Individuals who demonstrate disregard for the well-being of others, a lack of remorse for harming others, and illegal behaviors do not act in accordance with the core values of medicine and pose a significant threat to patients. From the first day of medical school through medical practice, patterns of behavior that run contrary to the goals of medicine should be monitored and treated in the same manner as gross incompetence. The response should be both rapid and fair for the protection of patients and physicians. Medical boards should have and exercise the authority to permanently revoke or suspend medical licenses for first-time egregious offenses that run counter to the core values of medicine (e.g., rape or risky

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

unnecessary invasive procedures done for profit) or for repeated lesser offenses following remediation efforts. Medical schools and institutions sponsoring residencies and fellowships should exercise their authority to dismiss medical students, residents, and fellows on the same grounds.

8. *Partner with Law Enforcement in Appropriate Ways*

Given different standards of evidence and procedures, administrative review of cases (e.g., of sexual abuse) by state medical boards may provide less stressful approaches to investigation and adjudication for patients who have been victimized, compared to criminal investigations. Boards typically also have the authority to remove a physician from medical practice more swiftly than criminal systems. Nevertheless, the protection offered to the public by administrative review and action may fall short of that provided by criminal prosecution. Boards should routinely ask patient victims (e.g., victims of sexual abuse) whether they want to work with law enforcement to pursue criminal charges. Patients' wishes not to pursue such charges should be respected. Boards should be mindful of their obligation to work with law enforcement in cases involving mandatory reporting. We encourage law enforcement to provide boards with highly trained liaisons to support investigations involving all relevant criminal activities, including unnecessary invasive procedures and sexual abuse, in ways similar to the support provided for investigating inappropriate opioid prescriptions and false claims.

9. *Provide Patients with Educational Materials to Inform Expectations and Choices*

Patients must not shoulder the burden of ensuring competent and professional service from physicians. However, it is appropriate to empower patients by providing information to inform reasonable expectations. For example, it would be appropriate to provide patients with written information on the use of chaperones for intimate examinations and how a well woman exam or a sports physical is appropriately conducted. Patients should be provided with information, such as American Board of Internal Medicine's *Choosing Wisely* brochures, that describe when invasive procedures are indicated,[72] as well as the right to request a second opinion, particularly if patients have any reservations about the medical necessity of procedures. Vulnerable patients should have access to patient advocates and consent monitors when considering invasive or risky procedures.

10. *Conduct Basic Research to Understand the Factors that Lead to Egregious Ethical Violations*

Very little data exist that help to explain how and why egregious ethical violations occur in medical practice. Effective prevention and remediation efforts will require access to detailed data on cases and novel analytic approaches to identify causal factors. We recommend that state medical bards and the NPDB partner with researchers to identify data points to collect when investigating and reporting cases and eliminate the use of vague descriptions of the reasons for disciplinary action such as "not applicable" and "other."

Some studies have found rates of board certification among wrongdoers to be significantly lower than those of the general U.S. physician population.[1,2,73,74] However, no data identify the specific factors associated with board certification that might be protective of integrity in medicine. Accordingly, at this time, we recommended further research to understand the specific elements of post-graduate training that may enhance competence and professionalism in medicine.

While the vast majority of male physicians are never sanctioned by a state medical board,[8] the overwhelming majority of physicians who commit egregious ethical violations are male.[1,2,57,60] The impact of increased gender diversity on overall professionalism in medicine is worthy of study, including gender diversity in positions of leadership within medical centers and healthcare institutions.[75,76]

It is important to conduct research aimed at identifying barriers and facilitators to implementing reforms, and to track and evaluate progress in implementing reforms.

It is appropriate for agencies and institutions that support research on health care—including the National Institutes of Health and the Agency for Healthcare Research and Quality—and institutions that are directly responsible for oversight of medical practice—including the FSMB, the Joint Commission, and all health care systems—to support research on these topics.

While these 10 recommendations focus on the field of medicine, we acknowledge that protecting patients requires that all health care professionals abide by high standards. We encourage medical societies and health care institutions to work with state medical boards and allied health-credentialing boards to consider the steps necessary to prevent

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

and appropriately respond to egregious ethical violations by all health care professionals.

Conclusions

The responsibility for reducing egregious ethical violations belongs to the field of medicine and health care leadership. Patients, medical students, and nurses may observe egregious ethical violations. However, patients may not want to relive trauma when they have been victimized, and medical students, nurses and junior colleagues may fear retaliation and career harm if they act as whistle-blowers. This is particularly true in institutional cultures that are tolerant of wrongdoing or unprofessional behavior. None of the recommendations we offer depend upon increased action from vulnerable groups, though some of them support such action, for example, when patients who were victimized wish to cooperate with law enforcement.

While the vast majority of physicians are committed to the well-being of their patients and behave with professional integrity, a small minority repeatedly commit egregious ethical violations. We embrace the goals of making such violations significantly less frequent and, when they do occur, identifying them sooner and taking the steps necessary to ensure they are not repeated. The 10 recommendations offered by our working group provide a schematic design to meet these goals. Implementation of these recommendations will require the commitment of specific groups following debate and refinement of the recommendations. Above we recommended specific actions for the FSMB, namely, that it "provide leadership by sharing best practices across state medical boards," publish "examples of sensible and effective model statutes" (e.g., rules for mandatory reporting, whistle-blower protection, mandatory revocation, and public reporting), and support collaborative research aimed at understanding predictors of egregious violations and barriers and facilitators to implementing reforms.

While full implementation of appropriate measures will take time and study, we believe it is urgent to take visible actions to acknowledge and address the problem at hand. ■

Financial Support and Conflicting Interests: This research was supported by grants from the National Institute of Aging (1R01AG043527) and National Center for Advancing Translational Sciences (UL1TR000448). The authors have no relevant financial conflicts of interest to disclose.

About the Authors

James M. DuBois, DSc, PhD, is a Steven J. Bander Professor of Medical Ethics and Professionalism, Professor of Psychology, and Director of the Bioethics Research Center at Washington University School of Medicine.

Emily E. Anderson, MPH, PhD, is an Associate Professor in the Neiswanger Institute for Bioethics, Stritch School of Medicine, Loyola University Chicago.

John T. Chibnall, PhD, is an Adjunct Professor in the Department of Psychiatry in the School of Medicine and in the Department of Psychology at St. Louis University.

Leanne K. Diakov, JD, serves as the General Counsel for the Kentucky Board of Medical Licensure.

David J. Doukas, MD, is the James A. Knight Chair of Humanities and Ethics in Medicine, and directs the Program in Medical Ethics and Human Values at Tulane University's School of Medicine.

Eric S. Holmboe, MD, MACP, FRCP, is Senior Vice President of Milestones Development and Evaluation at the Accreditation Council for Graduate Medical Education and holds adjunct appointments at Yale University and the Northwestern University Feinberg School of Medicine.

Heidi M. Koenig, MD, is a Professor of Anesthesiology and Perioperative Medicine at the University of Louisville School of Medicine and serves as Editor-in-Chief of the *Journal of Medical Regulation*.

Joan H. Krause, JD, is the Dan K. Moore Distinguished Professor of Law at the University of North Carolina School of Law.

Gianna McMillan, MA, is a Patient Representative for the FDA and is the Program Administrator for the Bioethics Institute, Loyola Marymount University.

Marc Mendelsohn, MD, MPH, is an Assistant Professor of Emergency Medicine at Mount Sinai Beth Israel and served as a member of the Council on Ethical and Judicial Affairs (CEJA) at the American Medical Association.

Jessica Mozersky, PhD, MBE, is an Assistant Professor of Medicine in the Bioethics Research Center at Washington University School of Medicine.

William A. Norcross, MD, is a Professor of Family Medicine at the UCSD School of Medicine and serves as Director of the Physician Assessment and Clinical Education program (PACE).

Alison J. Whelan, MD, is the Chief Medical Education Officer at the Association of American Medical Colleges (AAMC).

References

1. DuBois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases. *Sex Abuse: A Journal of Research and Treatment.* 2017:1079063217712217.
2. DuBois JM, Chibnall JT, Anderson EE, Eggers M, Baldwin KA, Vasher M. A mixed-method analysis of reports on 100 cases of improper prescribing of controlled substances. *Journal of Drug Issues.* 2016;46(4):457-472.
3. DuBois JM, Chibnall JT, Anderson EE, et al. Exploring unnecessary invasive procedures in the United States: A retrospective mixed-methods analysis of cases from 2008-2016. *Patient Safety in Surgery.* 2017;11(1):30.
4. American Medical Association Council on Ethical and Judicial Affairs. *Code of medical ethics of the American Medical Association.* Chicago, IL: American Medical Association; 2014-2015.
5. American Board of Internal Medicine, American College of

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

Physicians, European Federation of Internal Medicine. *Medical professionalism in the new millennium: A physician charter.* 2004.

6. Pellegrino ED. Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal.* 1995;5(3):253-277.
7. Brody H, Doukas D. Professionalism: A framework to guide medical education. *Medical education.* 2014;48(10):980-987.
8. Federation of State Medical Boards. *U.S. Medical Regulatory Trends and Actions.* Dallas, TX May 2014.
9. Harris JA, Byhoff E. Variations by state in physician disciplinary actions by U.S. medical licensure boards. *BMJ Quality & Safety.* 2017;26(3):200-208.
10. Peachman RR. What you don't know about your doctor could hurt you. *Consumer Reports.* April 20, 2016.
11. *National Center for Health Statistics. Health, United States, 2016: With Chartbook on Long-term Trends in Health.* 2017 2017.
12. Carr GD. Professional sexual misconduct-an overview. *Journal of the Mississippi State Medical Association.* 2003;44(9):283-300.
13. Ernsthausen J. Dangerous doctors, flawed data: Why a national tracking system doesn't show the extent of physician sexual misconduct. *Atlanta Journal-Constitution.* July 5, 2016.
14. Wolfe SM, Williams C, Zaslow A. *Public Citizen's Health Research Group ranking of the rate of State Medical Boards' serious disciplinary actions, 2009-2011.* Public Citizen; May 17, 2012.
15. Heumann M, Pinaire B, Burger S. Bad medicine: On disciplining physician felons. *Cardozo Journal of Conflict Resolution.* 2009;11:133-180.
16. DuBois JM. Understanding the severity of wrongdoing in healthcare delivery and research: Lessons learned from a historiometric study of 100 cases. *American Journal of Bioethics.* 2013;4(3):39-48.
17. Murphy D. Four new complaints filed against Larry Nassar, including one dating to '92. *ESPN.* 2017. http://www.espn.com/olympics/story/_/id/19191934/new-complaints-larry-nassar-allege-sexual-abuse-dates-1992.
18. Mack J, Lawler E. MSU doctor's alleged victims talked for 20 years. Was anyone listening? *MLive.* 2017. http://www.mlive.com/news/index.ssf/page/msu_doctor_alleged_sexual_assault.html.
19. BBC News. Larry Nassar case: USA gymnastics doctor 'abused 265 girls'. BBC; 2018.
20. Lawrence Nassar sentenced to 60 years in federal prison [press release]. Grand Rapids, MI, December 8, 2017.
21. Epstein J, Langford T. Ex-USA Gymnastics doctor Larry Nassar treated athletes in Texas without license, board confirms. 2018. https://sportsday.dallasnews.com/other-sports/moresports/2018/01/24/ex-usa-gymnastics-doctor-larry-nassar-treated-athletes-texas-without-license-board-confirms.
22. Kozlowski K. How MSU doc became suspect in dozens of rapes. *The Detroit News.* 2017. http://www.detroitnews.com/story/news/local/michigan/2017/08/10/rise-fall-larry-nassar/104491508/.
23. Teegardin C, Robbins D, Ernsthausen J, Hart A. License to betray: A broken system forgives sexually abusive doctors in every state, investigation finds. *Atlanta Journal-Constitution.* July 5, 2016.
24. Doctors and sex abuse: A broken system [Video]: *Atlanta Journal-Constitution,* 2016.
25. Norder L, Ernsthausen J, Robbins D. Why sexual misconduct is difficult to uncover. *Atlanta Journal-Constitution,* 2016.
26. Hall P. Doctor's role detailed in alleged drug ring. *The Morning Call, Inc.* June 30, 2013.
27. Southern West Virginia physician sentenced on drug charge [press release]. Wheeling, WV. October 13, 2011.
28. Doctor who supplied oxycodone ring sentenced in Manhattan federal court to 36 months in prison. [press release]. New York, NY: Federal Information and News Dispatch, Inc, December 18, 2012.
29. White K. Raleigh General, doctor sued over heart procedures. *Charleston Gazette-Mail.* February 26, 2015.
30. White K. Doctor: Patients injured, killed by procedures; Testimony reveals witness to unnecessary heart procedures. *Charleston Gazette-Mail.* August 15, 2016.
31. Carreyrou J, McGinty T. Medicare records reveal troubling trail of surgeries. *Wall Street Journal.* March 29, 2011.
32. Krause JH. A patient-centered approach to health care fraud recovery. *J Crim Law Crim.* 2006;96(2):579-619.
33. Judd A. State secrets: System shields doctors' abuse nationwide, leaves patients in dark. *Atlanta Journal-Constitution.* September 26, 2016.
34. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *New England Journal of Medicine.* 2005;353(25):2673-2682.
35. Papadakis MA, Arnold GK, Blank LL, Holmboe ES, Lipner RS. Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. *Ann Intern Med.* 2008;148(11):869-876.
36. Cuddy MM, Young A, Gelman A, et al. Exploring the relationships between USMLE performance and disciplinary action in practice: A validity study of score inferences from a licensure examination. *Academic Medicine.* 2017:1-6.
37. Prasad V. Are we treating professionalism professionally? Medical school behavior as predictors of future outcomes. *Teaching and Learning in Medicine.* 2011;23(4):337-341.
38. Carrese JA, Malek J, Watson K, et al. The essential role of medical ethics education in achieving professionalism: the Romanell Report. *Academic Medicine.* 2015;90(6):744-752.
39. Nichols BG, Nichols LM, Poetker DM, Stadler ME. Operationalizing professionalism: a meaningful and practical integration for resident education. *The Laryngoscope.* 2014;124(1):110-115.
40. American Board of Internal Medicine, American College of Physicians, European Federation of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Ann Intern Med.* 2004;136(3):1-2.
41. Hodges BD, Ginsburg SR, Cruess R, et al. Assessment of professionalism: Recommendations from the Ottawa 2010 conference. *Medical Teacher.* 2011;33(5):354-363.
42. Lifchez SD, Cooney CM, Redett RJ, 3rd. The Standardized Professional Encounter: A New Model to Assess Professionalism and Communication Skills. *J Grad Med Educ.* 2015;7(2):230-233.
43. Goss BD, Ryan AT, Waring J, et al. Beyond Selection: The Use of Situational Judgement Tests in the Teaching and Assessment of Professionalism. *Academic Medicine.* 2017;92(6):780-784.

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

44. Zhao Y, Zhang X, Chang Q, Sun B. Psychometric characteristics of the 360 degrees feedback scales in professionalism and interpersonal and communication skills assessment of surgery residents in China. *Journal of Surgical Education.* 2013;70(5):628-635.
45. Rodriguez E, Siegelman J, Leone K, Kessler C. Assessing professionalism: summary of the working group on assessment of observable learner performance. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine.* 2012;19(12):1372-1378.
46. Soeken D. Research ethics: Whistle-blowers have a tough time. *Nature.* 2014;505.
47. Schuchman M. Medical whistle-blower protection lacking. *Canadian Medical Association Journal.* 2008(12):1529.
48. Conway J. Getting boards on board: Engaging governing boards in quality and safety. *The Joint Commission Journal on Quality and Patient Safety.* April 2008;34(4):214-220.
49. *Teaching Medical Professionalism: Supporting the Development of a Professional Identity.* 2nd ed. Cambridge: Cambridge University Press; 2016.
50. Stern DT. *Measuring Medical Professionalism.* New York: Oxford University Press; 2006.
51. DuPree E, Anderson R, McEvoy MD, Brodman M. Professionalism: A necessary ingredient in a culture of safety. *The Joint Commission Journal on Quality and Patient Safety.* 2011 October;37(10):447-455.
52. Webb LE, Dmochowski RR, Moore IN, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *The Joint Commission Journal on Quality and Patient Safety.* 2016 April;42(4):149-161.
53. Norcross WA, Henzel TR, Freeman K, Milner-Mares J, Hawkins RE. Toward meeting the challenge of physician competence assessment: The University of California, San Diego Physician Assessment and Clinical Education (PACE) program. *Academic Medicine.* 2009;84(8):1008-1014.
54. Agrawal S, Tarzy B, Hunt L, Taitsman J, Budetti P. Expanding physician education in health care fraud and program integrity. *Academic Medicine.* 2013;88(8):1081-1087.
55. Pichert JW, Moore IN, Karrass J, et al. An intervention model that promotes accountability: Peer messengers and patient/family complaints. *The Joint Commission Journal on Quality and Patient Safety.* 2013 October;39(10):435-446.
56. Donnon T, Al Ansari A, Al Alawi S, Violato C. The reliability, validity, and feasibility of multisource feedback physician assessment: A systematic review. *Academic Medicine.* 2014;89(3):511-516.
57. Khaliq AA, Dimassi H, Huang C-Y, Narine L, Smego RAJ. Disciplinary action against physicians: Who is likely to get disciplined? *Am J Med.* 2005;118(7):773-777.
58. Studdert DM, Bismark MM, Mello MM, Singh H, Spittal MJ. Prevalence and characteristics of physicians prone to malpractice claims. *New England Journal of Medicine.* 2016;374(4):354-362.
59. Kohatsu ND, Gould D, Ross LK, Fox PJ. Characteristics associated with physician discipline: A case-control study. *Archives of Internal Medicine.* 2004;164(6):653-658.
60. Arora KS, Douglas S, Goold SD. What brings physicians to disciplinary review? A further subcategorization. *AJOB Empirical Bioethics.* 2014;5(4):53-60.
61. Choudry U, Barta RJ, Kim N. Current trends in chaperone use by plastic and reconstructive surgeons. *Annals of Plastic Surgery.* 2013;70(6):709-713.
62. Morreim EH. Malpractice, mediation, and moral hazard: The virtues of dodging the data bank. *Ohio State Journal on Dispute Resolution.* 2012;27(1).
63. Tricarico RP. A nation in the throes of addiction: Why a national prescription drug monitoring program is needed before it is too late. *Whittier Law Review.* 2016;37(117).
64. Ammons LL. Executive summary of special report submitted to the Honorable Jack Markell, Governor, State of Delaware, May 10, 2010, independent review of the Earl Brian Bradley case. *Widener Law Review.* 2013;19(1):1-49.
65. Krause JH. Following the money in health care fraud: Reflections on a modern-day yellow brick road. *American Journal of Law and Medicine.* 2010;36:343-369.
66. Buck ID. Furthering the fiduciary metaphor: The duty of providers to the payers of Medicare. *California Law Review.* 2016;104:1043.
67. AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003-2013. *PLOS One.* 2016:1-13.
68. Carr GD. Professional sexual misconduct- An overview. *Journal of the Mississippi State Medical Association.* 2003;44(9):283-300.
69. Hamilton N. Stopping doctor evil: How to prevent the prevalence of health care providers sexually abusing sedated patients. *Hofstra Law Review.* 2016;45(1):299-330.
70. Bal S, Brenner LH. The law and social values: Medical necessity and criminal prosecution. *Clinical orthopaedics and related research.* 2016;474(4):887-891.
71. Moody M. When courts do not protect the public: How administrative agencies should suspend professionals' licenses on an emergency basis. *Florida Coastal Law Review.* 2009;10:551-566.
72. Verdugo R, Nussbaum M, Claro M, et al. Preparing undergraduate computer science students to face intercultural and multidisciplinary scenarios. *IEEE Transactions on Professional Communication.* 2013;56(1):67-80.
73. Hawkins RE, Lipner RS, Ham HP, Wagner R, Holmboe ES. American Board of Medical Specialties Maintenance of Certification: theory and evidence regarding the current framework. *The Journal of Continuing Education in the Health Professions.* 2013;33 Suppl 1:S7-19.
74. Allen SH, Marier RL, Mouton C, Shankar A. Training matters: A retrospective study of physician disciplinary actions by the Louisiana State Board of Medical Examiners, 1990-2010. *Journal of Medical Regulation.* 2016;102(4):7-16.
75. Rochon PA, Davidoff F, Levinson W. Women in academic medicine leadership: Has anything changed in 25 years? *Academic Medicine.* 2016;91(8):1053-1056.
76. Zenger J, Folkman J. Are women better leaders than men? *Harvard Bus Rev.* 2012. https://hbr.org/2012/03/a-study-in-leadership-women-do. Accessed March 15.

Copyright 2018 Federation of State Medical Boards. All Rights Reserved.

Time to End Physician Sexual Abuse of Patients: Calling the U.S. Medical Community to Action

Azza AbuDagga, M.H.A., Ph.D, Michael Carome, M.D., and Sidney M. Wolfe, M.D.

Health Research Group, Public Citizen, Washington, DC, USA.

Despite the strict prohibition against all forms of sexual relations between physicians and their patients, some physicians cross this bright line and abuse their patients sexually. The true extent of sexual abuse of patients by physicians in the U.S. health care system is unknown. An analysis of National Practitioner Data Bank reports of adverse disciplinary actions taken by state medical boards, peer-review sanctions by institutions, and malpractice payments shows that a very small number of physicians have faced "reportable" consequences for this unethical behavior. However, physician self-reported data suggest that the problem occurs at a higher rate. We discuss the factors that can explain why such sexual abuse of patients is a persistent problem in the U.S. health care system. We implore the medical community to begin a candid discussion of this problem and call for an explicit zero-tolerance standard against sexual abuse of patients by physicians. This standard must be coupled with regulatory, institutional, and cultural changes to realize its promise. We propose initial recommendations toward that end.

KEY WORDS: medical board; sexual abuse; sexual misconduct; National Practitioner Data Bank; zero tolerance.

J Gen Intern Med
DOI: 10.1007/s11606-019-05014-6
© Society of General Internal Medicine 2019

The prohibition against physician sexual relations with their patients, which can cause lasting damage to patients, is one of the most universally agreed upon ethical principles in medicine. For example, in 1991, the American Medical Association (AMA) declared unequivocally that these relations are unethical, noting that this prohibition was incorporated into the Hippocratic oath.[1] Other professional medical organizations and state medical boards have echoed this stance.

Yet numerous reports of physicians who have violated this prohibition (such as the disgraced gymnastics physician, Lawrence Nassar) indicate that more definitive action is needed to prevent physician sexual abuse of patients in the U.S.A.

In this Perspective, we discuss the available evidence on the extent of physician sexual abuse of patients in the U.S.A. and factors that contribute to this problem, and we propose recommendations to safeguard against it.

Sexual contact between a physician and a patient or any behavior or remarks of a sexual nature by physicians toward patients have been legally considered sexual abuse since 1994 in Ontario, Canada, under the province's Regulated Health Professions Act, which defines sexual abuse as[2]: "(a) sexual intercourse or other forms of physical sexual relations between the [physician] and the patient, (b) touching, of a sexual nature, of the patient by the [physician], or (c) behavior or remarks of a sexual nature by the [physician] towards the patient." One explicit purpose of the Ontario law is "to eradicate the sexual abuse of patients by [physicians]." The term sexual abuse does not exist in U.S. state regulations of physicians. In lieu of "sexual abuse," the U.S. medical community, including the Federation of State Medical Boards (FSMB), uses the term "sexual misconduct" to characterize this unethical behavior. Although U.S. definitions of sexual misconduct tend to overlap with Ontario's definition of sexual abuse, the former term encompasses misconduct that does not involve patients and fails to connote the profound unethical nature of sexual relations between physicians and their patients.

DATA ON PHYSICIAN SEXUAL ABUSE AND SEXUAL MISCONDUCT

A 2017 exploratory analysis of 101 cases of physician sexual abuse of patients found that the primary forms of abuse in these cases were inappropriate touching (33%), sodomy (31%), rape (16%), child molestation (14%), and purportedly consensual sex (7%).[3] It also revealed that certain patient characteristics (such as female gender and young age) and certain physician characteristics (including male gender, age greater than 39, and consistently examining patients alone in nonacademic settings) were associated with physician sexual abuse.[3] However, the authors concluded that "there were no necessary conditions for [sexual abuse] cases to occur except for the sexual urges of the physicians."

A 1998 study identified 567 U.S. physicians who were disciplined by state medical boards from 1981 through 1996 for sex-related offenses (including sexual intercourse, rape,

Prior presentation: *This perspective has not been presented or published elsewhere.*

Received May 1, 2018
Revised October 22, 2018
Accepted March 21, 2019

Published online: 01 May 2019

sexual molestation, and sexual favors for drugs), 75% of which involved patients. These violations would have been considered physician sexual abuse of patients as defined by the aforementioned Ontario law.[4]

Our 2016 analysis of data from the U.S. National Practitioner Data Bank (NPDB) showed that from January 2003 through September 2013, 862 physicians had state licensing disciplinary actions because of sexual misconduct, totaling 974 such actions.[5] These numbers represent fewer than 0.1% of all licensed U.S. physicians.[5] The U.S. rate of such disciplinary actions was approximately 9.5 per 10,000 physicians per 10 years. Importantly, the NPDB Public Use Data do not report any details about the nature of the sexual misconduct.

In comparison, data from a 2011 study of disciplinary actions by medical licensing authorities in Canada from 2000 to 2009[6] showed an approximate rate of disciplinary actions for sexual misconduct of 25.1 per 10,000 physicians per 10 years. Thus, the Canadian rate of discipline for sexual misconduct was 2.6 times higher than the U.S. rate. Like the U.S. study, the Canadian study did not characterize the nature of the sexual misconduct. Also, neither study reported the proportions of sexual misconduct that involved patients.

Despite the limitations of both studies, the difference in the rates of disciplinary actions for sexual misconduct by U.S. and Canadian medical licensing authorities likely reflects more frequent detection and disciplining of physicians who commit sexual misconduct in Canada rather than more frequent sexual misconduct by Canadian physicians; there is no evidence that Canadian physicians are more prone to sexual misconduct than U.S. physicians.

Studies analyzing reports of disciplinary actions for physician sexual misconduct likely underestimate the scope of the problem. For example, a 1996 anonymous random national survey of U.S. physician members of the AMA (response rate = 52%) showed that 3.4% of the respondents reported a history of personal sexual contact (genital–genital, oral–genital, or anal–genital) with one or more patients.[7]

FACTORS THAT ALLOW THIS PROBLEM TO PERSIST

Several factors may explain why physician sexual abuse of patients continues to be a persistent problem in the U.S.A. First, many cases of physician sexual abuse of patients go unreported. This is because patients may be shocked and consumed by feelings of disbelief, guilt, or shame; may be fearful that they will not be believed due to the significant power imbalance between physicians and their patients; or may be unwilling to publicly disclose the abuse. Additionally, victims may not know how to navigate the regulatory system to seek redress for the harms of physician sexual abuse, such as filing a complaint with the state medical boards that licensed the physicians. Even when they file complaints, victims can be further traumatized by the investigation and legal procedures, which may lead them to withdraw their complaints. Importantly, physicians often are unwilling to report their impaired or incompetent colleagues to relevant authorities,[8] likely due to the absence of enforceable legal mandates for such reporting.

Second, according to the FSMB, many hospitals and health care organizations regularly ignore or circumvent reporting requirements for medical boards regarding impaired physicians.[9]

Third, medical boards may not always act on complaints of physician sexual abuse of patients, especially when there is no material evidence or witnesses.[10, 11] A 2006 report found that two-thirds of all complaints received by medical boards were closed either due to inadequate evidence to support the charges or because these cases were resolved informally, through a notice of concern or a similar communication with the involved physician.[12] The report noted that only 1.5% of the overall complaints to medical boards reached the formal hearing stage.

There is evidence that even when medical boards discipline physicians for sexual abuse, those physicians often are permitted to resume medical practice. For example, a 2016 nationwide investigation of thousands of medical board orders for physicians who were disciplined for sexually abusing patients or other sex-related offenses since 1999 found that more than one-half of these physicians were still licensed to practice.[13] Little information exists on the effectiveness of possible safeguards, such as counseling of sexually abusive physicians, to prevent recidivism and possible harm to future patients. Additionally, the aforementioned 2016 NPDB analysis showed that medical boards did not discipline 70% of the physicians who had peer-review sanctions or malpractice payments made on their behalf due to sexual misconduct.[5]

PROPOSED RECOMMENDATIONS TO ADDRESS PHYSICIAN SEXUAL ABUSE OF PATIENTS

Physician sexual abuse of patients must be classified as "never events": No patient should ever experience any form of sexual abuse, or fear of being subjected to such behavior, by a physician. We offer the following recommendations as initial steps to reach this goal:

(1) Replace the term "sexual misconduct" currently used in the U.S. medical community with the term "sexual abuse" when referring to any physician conduct that meets the Ontario Regulated Health Professions Act's definition of the latter term. Furthermore, the U.S. medical community and all state medical practice acts, as the Government of Ontario and the Medical Council of New Zealand[14] did, should adopt an explicit "zero-tolerance" standard against all forms of physician sexual abuse of patients. This standard should be incorporated into all applicable policies and regulations governing U.S. physicians.

(2) Educate physicians at every stage of their training and careers about the enormity of sexual abuse of patients, how to avoid it, and how to seek help if they are struggling with challenges to their professional boundaries with patients.
(3) Educate the public about how to prevent, recognize, and report physician sexual abuse. This should be a shared responsibility between state medical boards and health care institutions.
(4) Encourage and facilitate patient and patient surrogate reporting of all forms of physician sexual abuse. This recommendation can be accomplished by having health care institutions and medical boards establish standardized processes, which should be made known to patients and their surrogates, for filing complaints regarding any physician sexual abuse they may have experienced or witnessed and hiring patient-advocate professionals with whom patients and their surrogates can be encouraged to discuss such allegations.
(5) The medical community should mandate reporting by physicians and other health care professionals of any witnessed or suspected physician sexual abuse of a patient and should institute necessary measures to prevent reprisal against individuals who make such reports. Penalties for failing to report physician sexual abuse of patients should be set and enforced. Educational bystander intervention training should be encouraged to equip physicians and other health care professionals with the skills necessary to take appropriate action if they witness or suspect physician sexual abuse of patients.
(6) Medical boards and health care institutions should investigate each complaint of alleged physician sexual abuse of patients and conduct hearings if there are grounds for proceeding (while providing due process for the accused physician and for patient witnesses). The 2006 FSMB guidelines for state medical boards for dealing with physician sexual misconduct are a good resource.[15] However, these guidelines need to be vetted further by other stakeholders to determine the best practices for handling these cases. Similar guidelines are needed for health care institutions. We acknowledge that innocent physicians may be falsely accused of sexual abuse. Therefore, all complaints of alleged physician sexual abuse of patients should be pursued fairly and through due process.
(7) Health care institutions and medical boards should discipline physicians who are found to have engaged in any form of sexual abuse of patients. Health care institutions should be required to report physicians found to have engaged in such behavior to the appropriate medical board. Clear penalties (including suspension and revocation of medical license and clinical privileges) should be established and enforced by the medical community. The severity and length of these penalties should be based on the severity of the type of sexual abuse. In no case should public safety be compromised for any financial consideration, such as the revenue generated by the offending physician.
(8) Health care institutions and medical boards also should report physicians who were found to have engaged in sexual intercourse or other forms of physical sexual relations or touching of a sexual nature of a patient to law enforcement authorities in all cases, not just when the victim is a child.
(9) Medical boards should disclose on their websites complete information concerning all disciplinary actions against physicians who have been found to have sexually abused their patients.
(10) Health care institutions and medical boards should establish and fund programs to provide subsidized psychological counseling for all patients who were found to have been abused by their physicians. These institutions can seek reimbursement for such costs from the sexually abusive physicians.
(11) Health care institutions should provide trained chaperones to act as "practice monitors" during breast, full-body skin, genital, and rectal exams, having previously discussed this issue when patients first seek care.[16] The offer should be made regardless of the physician's gender.[17]

CONCLUSION

It is time for the U.S. medical community to begin a candid discussion of what needs to be done to end physician sexual abuse of patients. Each medical board, professional organization, and health care institution should evaluate its current systems and procedures regarding this problem and should take comprehensive and stronger actions, including seeking legislation, to protect patients from all physicians who evade medical ethics, betray the trust of their patients, and exploit the patient–physician relationship for their own sexual gratification.

Corresponding Author: *Azza AbuDagga, M.H.A., Ph.D; Health Research Group, Public Citizen, Washington, DC, USA (e-mail: aabudagga@citizen.org).*

Author Contributions *All authors take responsibility for the integrity of this perspective: All authors conceived it; AbuDagga prepared the first draft; and AbuDagga, Carome, and Wolfe critically revised it. The authors thank Fiona Lynn, MPS, managing editor of Public Citizen's Health Research Group, for her work on editing this article, and thank Dr. Robert E. Oshel (Retired Associate Director for Research and Disputes, Division of Practitioner Data Banks, Health Resources and Services Administration, U.S. Department of Health and Human Services) for his in-kind contribution to their work on physician sexual abuse and for reviewing early drafts of this perspective.*

Funding *Funding was provided by Public Citizen Foundation.*

Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. JAMA. 1991;266(19):2741–2745.
2. Government of Ontario. Regulated Health Professions Act, 1991, S.O. 1991, c. 18. (Currency date: November 1, 2018). https://www.ontario.ca/laws/statute/91r18/v6. Accessed 15 March 2019.
3. **Dubois JM, Walsh HA, Chibnall JT, et al.** Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases [published online June 19, 2017]. Sex Abuse. https://doi.org/10.1177/1079063217712217. Accessed 15 March 2019.
4. **Dehlendorf CE, Wolfe SM.** Physicians disciplined for sex-related offenses. JAMA. 1998;279(23):1883–1888.
5. **AbuDagga A, Wolfe SM, Carome M, Oshel RE.** Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. PLoS One. 2016;11(2):e0147800.
6. **Alam A, Klemensberg J, Griesman J, Bell CM.** The characteristics of physicians disciplined by professional colleges in Canada. Open Med. 2011;5(4):e166–e172.
7. **Bayer T, Coverdale J, Chiang E.** A national survey of physicians' behaviors regarding sexual contact with patients. South Med J. 1996;89(10):977–982.
8. **Campbell EG, Regan S, Gruen R,** et al. Professionalism in medicine: results of a national survey of physicians. Ann Intern Med. 2007;147(11):795–802.
9. Federation of State Medical Boards. Position statement on duty to report. https://www.fsmb.org/globalassets/advocacy/policies/position-statement-on-duty-to-report.pdf. Published 2016. Accessed 15 March 2019.
10. **Moktadier A.** Sexual abuse in hospitals is more common than you think. https://www.vtx.com/en/health/525583/sexual-abuse-in-hospitals-is-more-common-than-you-think. Published 2018. Accessed 15 March 2019.
11. **Sakal M.** Misconduct claims against doctors raise concerns. *East Valley Tribune.* http://www.eastvalleytribune.com/local/mesa/misconduct-claims-against-doctors-raise-concerns/article_6e720470-8ba7-11df-9419-001cc4c002e0.html. Published July 11, 2010. Accessed 15 March 2019.
12. **Bovbjerg RR, Josephine G.** State Discipline of Physicians: Assessing State Medical Boards Through Case Studies. Washington, D.C: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; 2006.
13. **Hart A.** AJC doctors & sex abuse investigation sparks improved patient protection. AJC. http://doctors.ajc.com/impact/. Accessed 15 March 2019.
14. Medical Council of New Zealand. Sexual boundaries in the doctor-patient relationship. https://www.mcnz.org.nz/assets/News-and-Publications/2018-Review/2018-ReviewConsultation-Appendix-IDraft-statementSexual-boundaries.pdf. Published 2018. Accessed 15 March 2019.
15. Federation of State Medical Boards. Addressing sexual boundaries: Guidelines for state medical boards. https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf. Published 2006. Accessed 15 March 2019.
16. **Pimienta AL, Giblon RE.** The case for medical chaperones. Fam Pract Manag. 2018;25(5):6–8.
17. Committee on Ethics, American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 373: Sexual misconduct. Obs Gynecol. 2007;110(2 Pt 1):441–444.

Publisher's Note *Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*

HHS Public Access

Author manuscript

Sex Abuse. Author manuscript; available in PMC 2018 December 01.

Published in final edited form as:

Sex Abuse. ; : 1079063217712217. doi:10.1177/1079063217712217.

Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases

James M. DuBois[1], Heidi A. Walsh[1], John T. Chibnall[2], Emily E. Anderson[3], Michelle R. Eggers[1], Mobolaji Fowose[1], and Hannah Ziobrowski[1]

[1]Washington University School of Medicine, St. Louis, MO, USA

[2]Saint Louis University School of Medicine, St. Louis, MO, USA

[3]Loyola University Chicago, Stritch School of Medicine, Chicago, IL, USA

Abstract

A mixed-method, exploratory design was used to examine 101 cases of sexual violations in medicine. The study involved content analysis of cases to characterize the physicians, patient-victims, the practice setting, kinds of sexual violations, and consequences to the perpetrator. In each case, a criminal law framework was used to examine how motives, means, and opportunity combined to generate sexual misconduct. Finally, cross-case analysis was performed to identify clusters of causal factors that explain specific kinds of sexual misconduct. Most cases involved a combination of five factors: male physicians (100%), older than the age of 39 (92%), who were not board certified (70%), practicing in nonacademic settings (94%) where they always examined patients alone (85%). Only three factors (suspected antisocial personality, physician board certification, and vulnerable patients) differed significantly across the different kinds of sexual abuse: personality disorders were suspected most frequently in cases of rape, physicians were more frequently board certified in cases of consensual sex with patients, and patients were more commonly vulnerable in cases of child molestation. Drawing on study findings and past research, we offer a series of recommendations to medical schools, medical boards, chaperones, patients, and the national practitioners database.

Keywords

sexual abuse; medical ethics; medical professionalism; patient abuse; physician wrongdoing

Introduction

The American Medical Association's (AMA) Principles of Medical Ethics commits its members to "providing competent medical care, with compassion and respect for human dignity and rights," reporting "physicians deficient in character," and regarding

Reprints and permissions: sagepub.com/journalsPermissions.nav

Corresponding Author: James M. DuBois, General Medical Sciences, Washington University in Saint Louis, 4523 Clayton Avenue, Campus Box 8005, St. Louis, MO 63110, USA. duboisjm@wustl.edu.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

"responsibility to the patient as paramount" (AMA, 2014–2015). Although data indicate that most physicians practice medicine with integrity (Federation of State Medical Boards [FSMB], 2014), sexual misconduct is one of the common reasons for disciplinary action by medical boards (Arora, Douglas, & Dorr Goold, 2014; Grant & Alfred, 2007).

The FSMB defines "sexual violations" as "engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual …." Data indicate that sexual violations cause significant harms to patients. Some data suggest that patients who enter into "consensual" sexual relationships with their physicians are typically not mentally healthy, and these encounters occur most often where considerable disparities in power, status, and emotional vulnerability exist between physician and patient, rendering consent inapplicable (Carr, 2003). However, sexual misconduct includes much more than sexual intercourse with patients; it includes masturbating in the presence of patients, genital contact, and rape or sodomy (FSMB, 2010). Psychological sequelae of sexual misconduct for patients include depression, anger, drug and alcohol abuse, trust issues, and posttraumatic stress symptoms (Carr, 2003). These and other sequelae are similar to those observed in the general population of survivors of sexual violence (Centers for Disease Control and Prevention, 2016).

It is not possible to provide an accurate estimation of the frequency of sexual violations in medicine. Most patient-victims do not report sexual violations (Teegardin, Robbins, Ernsthausen, & Hart, 2016); one study estimated that fewer than 1 in 10 victims choose to report it (Tillinghast & Cournos, 2000). This is significantly lower than the overall rate of 36% of cases of rape or sexual assault in the United States reported to police by female victims (U.S. Department of Justice, 2016). Reasons for failing to report may include shame, fear of not being believed, not being aware of the abuse (e.g., if the patient was sedated), complicity in the violation (e.g., trading sex for drugs), and being confused as to whether abuse occurred (e.g., not realizing that an ungloved vaginal exam was unnecessary) (Carr, 2003; Ernsthausen, 2016). Hospitals or physician employers sometimes ignore reports of abuse or push for a resignation rather than reporting physicians to medical boards or law enforcement (Ernsthausen, 2016; Norder, Ernsthausen, & Robbins, 2016). When incidents of sexual abuse are reported to the National Practitioner Data Bank (NPDB), which tracks complaints against physicians, the most commonly used category of complaint is "Not applicable" (Grant & Alfred, 2007), suggesting that even when sexual violations are reported, they may not be defined as such. Moreover, NPDB policy prohibits the public—including researchers and reporters—from accessing identifiable records (U.S. Department of Health and Human Services, 2015), making it impossible to pursue further details on vaguely labeled cases. In reviewing board orders, court records, and news reports, *Atlanta Journal-Constitution* (*AJC*) investigative reporters "found about 70 percent more physicians were accused of sexual misconduct than the 466 classified as such in the public version of the data bank from 2010 to 2014" (Ernsthausen, 2016).

The best available prevalence statistics derive from imperfect sources: self-reports or cases actually reported to authorities, which, as noted above, is likely fewer than 10% of all cases. The percentage of physicians self-reporting sexual contact with patients ranges from 3% to 12% of male physicians and 1% to 4% of female physicians (Carr, 2003). Approximately,

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

7.1% of all sanctions issued from 1994 to 2002 by the FSMB were for sexual misconduct (Grant & Alfred, 2007). A recent summary of disciplinary reviews of physicians by the Council on Ethical and Judicial Affairs AMA found 11% of cases involved sexual contact with patients (Arora et al., 2014).

Prior Research

Due to the secrecy surrounding sexual misconduct in medicine, very little is known about the factors that cause or correlate with it. AbuDagga, Wolfe, Carome, and Oshel (2016) were the first to analyze NPDB data on sexual misconduct cases. They found that a greater number of abusers were 40 to 59 years of age when compared with the general population of physicians, but no other individual traits could be examined as NPDB's publicly available data do not include gender or medical specialization of abusers. They also found that 87% of victims were female, but were unable to determine the patients' presenting medical complaints or the types of sexual abuse that occurred.

A few studies have focused on physician participants in courses that address boundary violations, which may include sexual harassment of patients or colleagues as well as sexual misconduct involving patients. MacDonald and colleagues (2015) identified risk factors for referral to such courses. They found that 5% of participants scored in the moderate-to-severe range on a childhood trauma questionnaire, and that these scores were correlated with attachment anxiety, avoidance, and maladaptive beliefs. They concluded that their findings "support a potential link between childhood adversity and boundary difficulties" (p. 489). This conclusion, however, ignored the fact that 95% of participants did not have elevated childhood trauma scores, nor did their study include (or reference) a comparison group of nonviolating physicians to establish a control baseline.

Based on data from two cohorts of participants in their course on boundaries in medicine, Swiggart, Dewey, Ghulyan, and Spickard (2015) found that 35% to 36% of referrals were for sexual violations, with the remainder referred for sexual impropriety or sexual harassment. Participants consistently displayed a lack of knowledge of sexual boundary rules, for example, rules prohibiting physicians from dating patients prior to explicitly terminating the patient–physician relationship. Their findings do not address the many forms of sexual violation in which a lack of knowledge is an unlikely cause, such as molestation of children, trading prescriptions for sex with a drug-addicted patient, sexual abuse of a mentally ill or cognitively impaired patients, masturbating in the presence of a patient, sodomy, or rape of an anesthetized patient. A 2003 review article by Carr (2003) estimated that over 50% of physicians guilty of sexual violations receive psychological or other treatment and return to practice (often with monitoring requirements). The 2016 AJC investigation arrived at the same figure of 50% (Teegardin et al., 2016). A 2009 review of studies of disciplinary boards that reported the gender of the physician found that 97% of sexual abusers were male (Sansone & Sansone, 2009). Studies from reports by state medical boards indicate that actions for sexual violations occur most commonly in the medical fields of psychiatry, family/general practice, and obstetrics/gynecology (Carr, 2003; Sansone & Sansone, 2009; Tillinghast & Cournos, 2000). However, the mean and median year of publication of the 15 studies reviewed by Sansone and Sansone (2009) was 1995—more

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

than 20 years ago—and most of the studies examined data from earlier time periods. A recent review of participants in a physician health program found that physicians who were previously disciplined for a boundary issue were more likely to commit a sexual offense (Brooks, Gendel, Early, Gunderson, & Shore, 2012). This finding is consistent with the AJC investigation of sexual abuse in medicine, which reported on the "grooming" behaviors of physician offenders who may "test the waters to establish a general atmosphere of forced intimacy and to see if his target will protest" (Hart, 2016).

In summary, most studies that aim to understand factors associated with sexual misconduct in medicine are limited in important ways: They review data prior to 1995; other than physician gender and specialty, they do not have access to data about the physicians themselves or the practice context in which the abuse occurred and they do not differentiate more severe sexual violations (as outlined above by the FSMB) from other sexual boundary issues like inappropriate comments and flirting.

Present Study

This study examined sexual violations by physicians practicing medicine in the United States, which were reported from 2008 to 2015. We focused only on sexual abuse of patients by physicians; we did not examine inappropriate relationships with colleagues, subordinates, or trainees, or sexual abuse of nonpatients.

This study was exploratory. Our aims fall into two broad categories: Descriptive and theoretical. Our descriptive aim was to characterize the nature, duration, and number of violations; the patient-victims; the setting of the violation; the physician; the investigation; and the consequences to the physician. Our theoretical aim was to use a criminal law framework to examine how the motives, means, and opportunities in these cases culminated in sexual misconduct.

As with many studies that incorporate qualitative research methods, we strove to ensure a sample size large enough to guarantee saturation (Corbin & Strauss, 2014; Hennink, Hutter, & Bailey, 2011). With relatively homogeneous populations, samples as small as 12 frequently suffice to ensure saturation (Guest, Bunce, & Johnson, 2006). However, based on our previous research on professional breaches of conduct in medicine, we assumed sexual misconduct to be equifinal (George & Bennett, 2005), meaning that multiple causal pathways to sexual misconduct exist, necessitating a larger sample. Moreover, our research plan included comparing clusters of cases (formed statistically or theoretically), which also necessitated a sample large enough to produce multiple clusters of sufficient sample size to analyze statistically. Based on these considerations and our experience with similar projects, a sample size of ~100 was supportable (Vogt, Vogt, Gardner, & Haeffele, 2014).

Method

Design Overview

This study used an ex post facto, "causes of effects" case study design (Bennett & Elman, 2006; Silva, 2010). We used a case analysis method because it is best suited to studying phenomena that cannot be studied (for reasons of ethics or practicality) using a prospective

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

design (George & Bennett, 2005). We first identified 101 applicable cases of sexual violations, which represented 100% of cases identified through reviews of the literature. Next, each case was examined using a criminal law theoretical framework to understand the factors that characterized it and enabled it to occur. We then examined the set of cases as a whole to determine whether specific causal patterns or typologies emerged. Such mixed-methods approaches are commonly used to study complex social phenomena that may arise from diverse clusters of causal conditions, and they can yield rich exploratory findings (George & Bennett, 2005). In practice, this approach involved four sequential steps: (a) identify cases and case documents through systematic literature reviews, (b) conduct qualitative content analysis of documents to generate descriptive data on case attributes, (c) develop a theory of how each individual case occurred using a criminal law framework, (d) conduct cross-case analysis to identify typologies of cases and statistically test for significant differences across case types. Each step is described in detail below.

Identifying Cases and Case Documents

We conducted two literature reviews: The first was aimed at identifying cases; the second was aimed at identifying documents associated with individual cases. To be eligible for inclusion, a case had to involve a physician as the sexual abuser, involve a patient as the victim, be described in at least five documents including either medical board or legal documents (to enable content analysis of rich and trustworthy information), and be reported between the period of July 1, 2008 and June 30, 2015. The reporting time frame was established to support two methodological goals. First, we aimed to identify and analyze at least 100 cases because such a sample size is generally adequate for qualitative content analysis to identify relevant variables and establish trustworthy patterns (Vogt et al., 2014); hence, we searched back to 2008. Second, we aimed to ensure that case reporting was complete, including reporting on investigations and penalties; hence, we coded no cases that were so recent that complete investigation and reporting could not be guaranteed (Simonton, 2003).

To identify cases, we used the LexisNexis Law database, which archives statutes, case judgments, and legal opinions, and provides access to medical board and regulatory documents, as well as U.S. newspaper articles. With the assistance of two law librarians, we developed a Boolean search strategy, which was used to search LexisNexis Law:

> ((Physician OR Doc OR Doctor OR Dr OR Surgeon OR Psychiatrist OR Pediatrician) w/20 (Charg! OR Accus! OR Convict! OR Revok! OR Suspen! OR Disciplin! OR Fine! OR Sanction! OR Probation OR Censure! OR Arrest! OR Guilty)) w/40 (Rape OR Molest! OR Fondl! OR (Sex! w/2 (Assault! OR Abus! OR Misconduct OR exploit! OR boundary OR touch! OR contact OR behavior OR intercourse OR imposition)).

The search returned 5,420 records, 707 of which were relevant to sexual abuse of patients by physicians. The project coordinator reviewed the 707 records and found 149 distinct cases. Of these 149 cases, 48 were excluded as ineligible: 10 cases were too recent (i.e., the case had not yet been resolved either through board, criminal, or a civil action), 21 cases lacked

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

adequate literature to enable content analysis, and 17 cases were either too ambiguous or the protagonist was exonerated. We investigated the remaining 101 eligible cases.

The project manager assigned cases to research assistants (RAs), who were provided the material located through LexisNexis Law. RAs then conducted supplemental literature searches for each case to ensure adequate descriptions of the abuse, the physician, and the work environment. These searches were conducted using the sexual offender's name in a wider variety of databases and search engines, including LexisNexis Law, Google, the relevant state medical board websites, state circuit court access sites, Health Grades, the American Board of Medical Specialties' Certification Matters website, and the U.S. Office of the Inspector General's exclusions website. The mean number of documents or sources consulted for each case was 17, with an average of two legal documents and 25 pages of medical board documents examined.

RAs uploaded all literature to Adobe PDF Portfolio, which allowed the team to read, mark up, and search all documents associated with each case or all cases combined.

Qualitative Content Analysis: Generating Descriptive Data on Case Attributes

The first step in qualitative content analysis is to generate data through coding (Roller & Lavrakas, 2015). Our coding approach was deductive insofar as most codes were generated through the research team's prior literature reviews (DuBois, Anderson, et al., 2012; DuBois, Kraus, & Vasher, 2012) and research on diverse kinds of professional wrongdoing that involved coding more than 300 cases (DuBois et al., 2013; DuBois et al., 2016). Our approach was inductive insofar as new variables specific to sexual abuse of patients were identified during the coding process, and insofar as some existing variables needed to be operationally defined in new ways in the context of sexual abuse of patients. Accordingly, all cases were content analyzed twice: once using our initial deductive codes, and once using new and revised codes.

We developed a coding datasheet in Excel to code variables. Our final codebook tracked 58 variables: three variables describing the work setting, 11 variables describing the physician-abuser, four variables describing the patient-victims, nine variables describing the case characteristics and whistle-blower (where applicable), four describing the investigation, seven describing the consequences to the physician, a taxonomy of six different kinds of sexual abuse, and a taxonomy of 14 different kinds of professional wrongdoing in medicine that might accompany the sexual abuse. Forty-seven variables were coded dichotomously (yes/no); the remaining variables were coded as ordinal (e.g., physician age and duration of the sex abuse) or categorical (e.g., medical specialization practice ownership model).

The coding datasheet included operational definitions of all variables. Some variables (such as gender, age, duration of the case, and board certification) were relatively easy to operationalize. Here, we describe the several variables that required significant deliberation by the team because they are not manifest. We defined "suspected personality disorder" as meeting at least two criteria for *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) diagnosis of antisocial personality, such as engaging in illegal behaviors (apart from the sexual abuse) or exhibiting

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

a lack of remorse (e.g., repeated wrongdoings even when it was evident that the behavior was harmful; APA, 2013). The classification of sexual crimes diverges significantly across jurisdictions. While the federal Uniform Crime Reporting program recently redefined rape to include most forms of sodomy (U.S. Department of Justice, 2014), we defined *rape* as penetration of the mouth, anus, or vagina by a penis without consent, and "sodomy" as penetration of the anus or vagina by anything other than a penis without consent (Tracy, Fromson, Long, & Whitman, 2012). We adopted the distinction between rape and sodomy—widely recognized in state criminal law—because a more specific taxonomy of behaviors enabled us to examine whether the two behaviors exhibited different patterns. We operationalized "lack of oversight" (an environmental factor that provides opportunity for misconduct) in the following manner: "In no instance was another person in the room when the event occurred." We used the "no instance" threshold because this provided the best indicator of causality: If abuse occurred with someone present (e.g., a chaperone such as a nurse or a family member), then presumably lack of oversight was not essential to the perpetration. All patients are vulnerable: They typically present with health concerns and are generally expected to comply with physician orders, including undressing. Nevertheless, we wanted to identify patients who were especially vulnerable. We operationalized "vulnerable" as belonging to a protected class (e.g., minors or older adults) or exhibiting cognitive impairments (e.g., due to anesthesia or severe mental illness).

For several reasons, we used one RA as the primary coder of each case: First, identifying, reading, and coding all documents associated with a case required more than 20 hr; second, in past studies using a similar methodology, we had very high interrater reliabilities for coding of variable (DuBois et al., 2013); third, we identified alternative means of ensuring the trustworthiness of coding. With respect to the latter, following coding by RAs, a PhD-level member of the team read two to three key documents on the case and examined the completed coding datasheet to ensure completeness, accuracy, and consistency. Concerns with coding were discussed at weekly team meetings. In addition, we examined the frequency with which different RAs used codes; when scores were discrepant (significant chi-square test, $p < .05$), we investigated whether this was due to true differences in the cases, and if not, provided further training on coding or refined our definitions of variables to ensure consistent use of codes.

Identifying Causal Factors in Individual Cases Using a Criminal Law Theory

A second phase in qualitative content analysis involves *interpreting* data generated in Phase 1 (Roller & Lavrakas, 2015). We applied a criminal law framework to each case by asking what provided the motive, means, and opportunity (MMO) needed to give rise to sexual abuse of a patient (Jones, 2010; Maguire, Reiner, & Morgan, 2007). In criminal law, the broad meaning of motive is "an emotion or state of mind that prompts a person to act in a particular way …" (Leonard, 2001, p. 445). As psychological states, motives cannot be known directly; thus, "it is necessary to resort to circumstantial evidence of its existence" (Leonard, 2001, p. 447). Based on systematic literature reviews (DuBois, Anderson, et al., 2012; DuBois, Kraus, & Vasher, 2012) and past coding of cases (DuBois et al., 2013; DuBois et al., 2016), we developed a deductive coding scheme for perpetrator traits and motives as well as environmental factors that might provide opportunity. Traits and motives

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

include sex, substance abuse, ambition, suspected antisocial personality disorder, carelessness, severe mental disorders, financial gain, poor problem solving, job pressure or stress, and other; environmental factors included ambiguous norms, vulnerable victims, corrupt moral climate, oversight failures, conflicting roles, lack of oversight, and other. It was generally not necessary to form a theory of the means of sexual abuse, as most adult males (100% of our sample) have the means by definition.

In the Excel codebook, RAs were provided with lists of MMO variables. The code-book operationally defined each of these variables, explaining how they might provide a motive, means, or opportunity for the sexual abuse. RAs were required to provide a rationale for the variables they selected, writing their own theory of the case—that is, they were required to explain how it arose using the MMO framework. These codes and rationales were examined by a PhD-level coinvestigator using the same process described above.

Developing Typologies of Sexual Abuse in Medicine

In a previous study of 100 cases of improper prescribing of controlled substances by physicians, our team successfully developed and validated typologies through a twofold process: Qualitative cross-case analysis of cases (George & Bennett, 2005) and cluster analysis (Namey, Guest, Thairu, & Johnson, 2008). The purpose of typology development was to identify how the causal factors in individual cases clustered together across cases in meaningful ways to explain the occurrence of sexual abuse. It is important to note that typology development may be used to reduce data—that is, to identify a small number of meaningful patterns among a larger set of cases (Namey et al., 2008)—or to identify the full universe of possible causal patterns, which in principle could equal the number of cases (Elman, 2005; Ragin, Shulman, Weinberg, & Gran, 2003). In this study, as with our previous study, we adopted a data reduction approach; we sought to identify from our 101 cases a small number of meaningful causal patterns using qualitative analysis guided by MMO theory and statistical analysis to confirm the patterns.

Findings

Our data analysis yielded two kinds of findings: Findings from our Phase 1 coding, which generated descriptive data on case attributes, and findings from our Phase 2 coding of causal factors and the accompanying cross-case analysis aimed at reducing these data to typologies or meaningful clusters of causal factors.

Descriptive Data on Case Attributes

Our data set included diverse kinds of sexual abuse of patients. For each case, the primary form of sexual abuse was defined as the behavior that was the focus of investigation—typically the most serious of the forms of abuse; for example, in a case that involved both sodomy and inappropriate touching, we would typically treat sodomy as the primary form of abuse. In 33% of cases, the primary form of abuse was inappropriate touching; in 31% of cases, it was sodomy; in 16% of cases, it was rape; in 14% of cases, it was child molestation; and in 7% of cases, it was consensual sex. As indicated in Table 1, perpetrators often committed multiple kinds of sexual abuse, as well as other ethical violations associated with

interprofessional relationships (e.g., sexual harassment), financial fraud, improper prescribing, and criminal behavior. This multifactorial nature of the cases complicated analysis aimed at characterizing specific kinds of abuse (see "Cross-case analysis" subsection below). Chi-square analyses indicated that physicians who primarily engaged in child molestation, sodomy, and rape were much more likely to also act inappropriately toward patients through touching/comments (87%–100%), compared with physicians who engaged in consensual sex (0%), $p < .001$ (Cramer's V, a fourfold point correlation, was used to indicate effect size; $V = .78$). Furthermore, physicians who engaged in child molestation were more likely to commit other sexual offenses with patients (e.g., exhibitionism, voyeurism; 43%) than physicians engaging in other forms of sexual abuse (6%–19%), $p < .05$, $V = .31$. Finally, physicians who raped patients were more likely to also improperly prescribe pharmaceuticals (56%) than physicians engaging in other forms of abuse (13%–30%), $p < .05$, $V = .33$.

Table 2 presents comprehensive frequencies for case attributes. Here, we highlight descriptive findings present in greater than 50% of cases. Although, approximately, 17% of physicians who completed a residency program over the past decade work full-time in academic medicine (American Association of Medical Colleges, 2016), nearly all (94%) cases occurred in nonacademic, private practice settings. No other feature of the workplace such as practice size or physician ownership status characterized a majority of cases. Nothing peculiar to our sampling approach would explain this finding nor are reporting rules different for academic medical centers. One hundred percent of perpetrators were male (in contrast to the average of 66% of U.S. physicians being male), and nearly all (92%) were older than the age of 39 (in contrast to the U.S. average of 78% of physicians during our study period; Young et al., 2015). A majority (69%) of perpetrators were not board certified (in contrast to the U.S. average of 24% of physicians; Young et al., 2015). This rate was unexpectedly high, and led us to add it as an inductive theory of the case variable in efforts to reduce data to typologies or clusters. Most cases involved more than five victims (57%) who were adults (60%) and women (89%). In 96% of cases, the abuse was repeated; in 58% of cases, it lasted for more than 2 years. Nearly all (88%) cases involved multiple kinds of professional breaches. In 85% of cases, patients were always examined alone. The AMA, the American Academy of Pediatrics, and the American Congress of Obstetricians and Gynecologists all state that a patient's request for a chaperone should be honored, none of them require the use of chaperones, and only seven states require chaperones under some conditions (American Academy of Pediatrics, 2011; American Congress of Obstetricians and Gynecologists, 2016; AMA, 2014–2015). No data exist indicating how frequently patients are intimately examined without a chaperone or how often chaperone policies are violated. Whistle-blowers in 69% of cases were patients. Most cases involved investigations by medical boards (94%) and criminal prosecutors (89%). In a majority of cases (87%), the perpetrator lost or surrendered his medical license; however, the loss of licensure was often temporary or restricted to one state, and long term, a lower percentage discontinued practicing medicine (74%).

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Cross-Case Analysis of Causal Factors and Typologies

We attempted to form clusters of cases based on the primary form of sexual abuse, practice type, board certification, suspected antisocial personality disorder, and opportunity factors such as a lack of oversight or particularly vulnerable patients using two-step cluster analysis (SPSS Statistics). The analysis was restricted to variables with distributions amenable to statistical analysis and that were expected to differentiate among sexual abuse types. The analysis failed to produce interpretable clusters, perhaps due to the significant overlap of sexual abuse and unethical behaviors engaged in by the physicians.

Next, we compared the primary sexual abuse groups on the remaining cluster variables, as shown in Table 3. Three variables differed significantly across the forms of sexual abuse: vulnerable patients ($V = .60$, $p < .001$), suspected antisocial personality ($V = .50$, $p < .001$), and being board certified ($V = .31$, $p < .05$). By definition, all child molestation cases involved especially vulnerable patients; in all other forms of sexual abuse, a minority of cases involved especially vulnerable patients, though sometimes vulnerability was induced (e.g., through drugging). Suspected antisocial personality disorder was present in a majority of rape cases (81%), but in a minority of all other cases. While this rate is high, our overall rate in the sample of 101 sexual offenders was 32%, which is largely in keeping with major studies of the prevalence of antisocial personality among male prisoners, which ranges from 35% to 47% (Black, Gunter, Loveless, Allen, & Sieleni, 2010; Fazel, 2002). A majority (71%) of physicians were board certified in the consensual sex cases, but in all other cases, only a minority were board certified, with rates dropping as low as 19% for sodomy and 18% for rape.

Discussion

In this study, we examined 101 cases of sexual abuse of patients by physicians. For each case, we described case characteristics and identified factors that provided the motives, means, and opportunities for the sexual abuse. The primary motives in most of the cases appeared indistinguishable from the acts themselves. That is, no motive was apparent other than the performance of the sexual act itself. This is, for example, quite distinct from prescribing opioids for the sake of financial gain or to garner sexual favors. Yet, it is also consistent with the determination of motive in criminal law: Sexual gratification may count as a motive in sexual assault cases, and sexual fetish may count as motive in other sexual crimes (Leonard, 2001). Accordingly, we assumed that the act itself was motivating to the perpetrator and looked for other factors such as suspected antisocial personality disorders or substance use disorders that might additionally provide motive (in the sense in which the term is used in criminal law). The matters of establishing fundamental means and opportunity were also simple: Most people have the physical means of sexually abusing another person, and within Western cultures, most physicians have the social authority to instruct patients to disrobe and to examine them in a setting without oversight.

A striking feature of these cases is that they can occur without obvious "red flags": Across all cases, except rape, cases commonly occurred without obvious signs of a personality disorder, they occurred in both solo and larger medical practices alike, and they involved

Author Manuscript

patients who were particularly vulnerable as well as patients who exhibited no special vulnerabilities other than being a patient.

Thus, there were no necessary conditions for cases to occur except for the sexual urges of the physicians. The only highly consistent markers were male gender (100%), age > 39 (92%), not being board certified (72% of nonconsensual sex cases)—even though 75% of physicians were board certified during the period under investigation (Young, Chaudhry, Rhyne, & Dugan, 2011)—consistent examination of patients alone (85%) in nonacademic medical settings (94%). While this is actually a rich cluster of five variables that occurred in >70% of cases, it is also somewhat unremarkable: In the vast majority of physician encounters that involve these traits, no sexual assault occurs. Thus, these are best understood as risk factors for sexual assault, particularly when combined, rather than sufficient conditions.

Almost all cases involved repeated abuse (96%) of multiple victims that continued for more than a year (73%), a fact consistent with earlier studies indicating that a very strong predictor of board sanctions is previous board sanctions (Grant & Alfred, 2007).

Recommendations

We offer recommendations to medical schools, medical boards, chaperones, the NPDB, and patients.

For medical schools—Forty percent of our cases involved either inappropriate touching (commonly labeled a "boundary violation" in medicine) or consensual sex. Swiggart et al. (2015) observe that some such violations occur due to ignorance regarding professional standards. The basic material taught in sexual boundary remediation training courses should be a standard part of training in medical professionalism. Medical students who engage in rape or sodomy—for which ignorance can be no excuse—should not receive medical degrees, and should be reported to law enforcement when appropriate. Data indicate that professional breaches during medical training (medical school and residency programs) predict future breaches as a physician (Papadakis, Arnold, Blank, Holmboe, & Lipner, 2008; Papadakis et al., 2012; Papadakis et al., 2005; Teherani, Hodgson, Banach, & Papadakis, 2005). Medical students should be taught the prevalence of sexual abuse by physicians and be encouraged to be vigilant and to report suspected abuse. They should also be trained on best practices for responding immediately when abuse is observed, building on professionalism training programs that teach medical students, residents, and physicians how to respond to observed unprofessional behavior (Hickson, Pichert, Webb, & Gabbe, 2007).

For medical boards—As noted in our introduction, it was often difficult or impossible to obtain data on cases of sexual abuse in medicine. States should make board documents open access. Several states do not allow public access to any documents or put up barriers to obtaining them (such as having to submit a written request for documents or pay a fee per page). It is concerning that the FSMB's 2010 report, "Addressing Sexual Boundaries: Guidance to State Medical Boards," nowhere mentions the possibility of reporting cases to police or other authorities (FSMB, 2010). Boards should be mandatory reporters whenever patients—who are vulnerable by definition and expected to be compliant with physician

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

orders—are sexually abused by physicians. At a minimum, boards should be held harmless if they report credible allegations of sexual abuse to authorities. At present, only 11 states have laws requiring medical boards to report sexual abuse to the police or prosecutors when the victim is an adult (Teegardin et al., 2016).

We do not expect impetus for such change to come from leading medical associations. The AMA not only lobbied strongly for the current secrecy of the NPDB, but it may also be moving in a counterproductive direction with its Code of Medical Ethics. In the 2015 version of the AMA Code, it stated clearly, "Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct" (section 8.14). The section of the code on "sexual misconduct" has now been renamed "Romantic or Sexual Relationships with Patients"; it remains open to the idea that such relationships "*may* exploit the vulnerability of patients …and ultimately be detrimental to the patient's well-being" (section 9.1.1, emphasis added). Impetus for change in reporting rules is thus more likely to come from the public and state legislatures, largely due to investigations by the AJC, other media outlets, and researchers.

For chaperones—Chaperones cannot be blamed for the sexual violations of physicians. Nevertheless, 19% of our cases of sodomy occurred with a chaperone, parent, nurse, or other individual in the room with the patient-victim and physician. Yet, only 6% of cases occurred in academic medical settings, where it is common to have residents involved in care and medical students *actively observing*. (In addition, nearly all physicians in academic medicine are board certified.) It is not enough for a chaperone to be present. If a nurse is in the room, doing paperwork or intentionally not observing to respect privacy or to avoid implying mistrust (factors sometimes explicitly mentioned in case literature), then it leaves open the possibility of inappropriate touching and sodomy (e.g., inserting a finger in an anus unnecessarily while making eye contact and smiling at a patient). Chaperones would benefit from formal training (Walzer & Miltimore, 1994) on how to respect privacy while providing appropriate oversight, and how to speak up when behavior appears to be inappropriate.

For the national practitioner data bank—As noted in our introduction, we are not able to provide trustworthy statistics on the prevalence of sexual abuse in medicine nor obtain crucial data on factors that might predict such cases except by using large convenience samples of cases that have been reported publicly or gone to court. NPDB should eliminate the category "Not applicable." It is unhelpful, overused, and unnecessary; it enables nonreporting of sexual abuse and other serious, sometimes criminal, offenses. NPDB should share identifiable data with researchers using the same protections of confidentiality via data use agreements that physicians routinely use when doing research with protected health information, including sensitive information such as patients' HIV status, genetic test results, and substance use history. Withholding this information from researchers thwarts a legitimate public health interest in understanding and preventing sexual abuse of patients.

For patients—Some of our cases involved minors being examined without parents or chaperones; some involved patients who suspected inappropriate behavior at the time of examination, but were too surprised or confused to speak up; other cases involved patients who ignored inappropriate remarks and touching until physician behavior escalated to sexual

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

assault. Patients are never to be blamed for sexual abuse by physicians, and medical schools, medical boards, and the NPDB have responsibilities to protect patients through prevention, detection, and discipline. However, patients also need to be empowered when dealing with situations that are routinely experienced as disempowering.

If a patient is sexually assaulted, we recommend involving the police; lodging a complaint with health care administrators may enable physicians to maintain licensure, abuse to continue, and abuse to be underreported. If a patient is unsure why a physician is asking him or her to undress or questions the medical necessity of an examination, we recommend asking the physician for an explanation. We recommend against allowing children to be examined alone. If a child or teenager requires a conversation or exam without a parent present, we recommend the presence of a nurse or other chaperone. If abuse occurs in the presence of a chaperone, we encourage patients or parents not to second guess themselves or think they did not see what they thought they saw. Sodomy can occur discretely and others may not notice; the presence of another may not be enough to discourage the behavior. Nineteen percent of our sodomy cases occurred with another person present in the examination room. Patients should be encouraged not to ignore inappropriate sexual remarks or inappropriate touching; sex abusers frequently engage in such activities as a form of grooming or testing the waters prior to more aggressive forms of abuse. In 94% of cases of sodomy and 88% of cases of rape, the abuse was preceded by inappropriate comments or touching of the victim or other patients.

Limitations and Future Research

A limitation of any content analysis approach using historical documents is that the absence of the variable in a document does not necessarily mean it was absent in the event described in the document; hence, the methodology risks underreporting the presence of variables.

General limits of an ex post facto design include the inability to obtain random samples from the larger population of cases and the inability to control for possible confounding variables using randomization. Accordingly, this study must be described as exploratory. It would be natural to call for a larger, more generalizable follow-up study; however, such a study will not be possible until fundamental changes are made to the way that we track and report such cases (U.S. Department of Health and Human Services, 2015).

These cases were skewed toward more serious crimes: Although accurate, comprehensive data on the frequency and kinds of sexual abuse in medicine are nonexistent for reasons explained in the introduction, we would expect that consensual sex and inappropriate touching are more common than rape (in part, due to the popularity of courses for physicians on "boundary issues"; Brooks et al., 2012; MacDonald et al., 2015; Spickard, Swiggart, Manley, Samenow, & Dodd, 2008); yet our sample included slightly more cases of rape and sodomy than consensual sex and inappropriate touching. We tried to minimize the impact of this by presenting our theory of the case variables (physician and environmental characteristics) broken down by type of abuse, comparing the frequencies across types.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Conclusion

Due to many factors, including vague, incomplete reporting and underreporting by patients and professional bodies alike, as well as rules shrouding disciplinary databases in secrecy, we cannot accurately estimate the prevalence of sexual violations in medicine. We do know that sexual misconduct in medicine goes well beyond the more commonly discussed concerns with sexual boundary issues and consensual sex with patients; it can include crimes such as child molestation, sodomy, and rape. When sexual violations occur, they most often are repeated by physicians, who perpetrate such behavior for years before being stopped. These facts indicate the need for reform among state medical boards and the NPDB, as well as the need to educate patients and chaperones. In response to the sexual scandal in the Roman Catholic Church, a document was developed and endorsed by the United States Conference of Catholic Bishops (2001) committing bishops and church leaders to report all credible allegations to authorities, to provide training to those in regular contact with children on child safety, and to develop policies and procedures to prevent the transfer rather than removal of perpetrators. It is time for the AMA, the FSMB, and other physician leadership and oversight groups to provide similar leadership to protect patients from the small minority of physicians who engage in sexually abusive acts.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by grants from the National Institute of Aging (1R01AG043527) and National Center for Advancing Translational Sciences (UL1TR000448).

References

AbuDagga A, Wolfe SM, Carome M, Oshel RE. Cross-sectional analysis of the 1039 U.S. physicians reported to the national practitioner data bank for sexual misconduct, 2003–2013. PLoS ONE. 2016; :1–13. DOI: 10.1371/journal.pone.0147800

American Academy of Pediatrics. 2011 policy statement—Use of chaperones during the physical examination of the pediatric patient. Pediatrics. 2011; 127:991–993. [PubMed: 21518716]

American Association of Medical Colleges. Table C7: Full-time faculty-appointment status at U.S. medical schools for residents who completed specialty: Residents who completed training, 2006–2015. 2016. Retrieved from https://www.aamc.org/data/448498/c7table.html

American Congress of Obstetricians and Gynecologists. Ethics opinion on sexual misconduct. 2016. Retrieved from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Sexual-Misconduct

American Medical Association. Code of medical ethics of the American Medical Association. Chicago, IL: Author; 2014–2015. (Section II, Definitions, Para 4)

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5. Arlington, VA: American Psychiatric Publishing; 2013.

Arora KS, Douglas S, Dorr Goold S. What brings physicians to disciplinary review? A further subcategorization. AJOB Empirical Bioethics. 2014; 5(4):53–60. DOI: 10.1080/23294515.2014.920427

Bennett A, Elman C. Qualitative research: Recent developments in case study methods. Annual Review of Political Science. 2006; 9:455–476. DOI: 10.1146/annurev.polisci.8.082103.104918

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Black DW, Gunter T, Loveless P, Allen J, Sieleni B. Antisocial personality disorder in incarcerated offenders: Psychiatric comorbidity and quality of life. Annals of Clinical Psychiatry. 2010; 22:113–120. [PubMed: 20445838]

Brooks E, Gendel MH, Early SR, Gunderson DC, Shore JH. Physician boundary violations in a physician's health program: A 19-year review. Journal of the American Academy of Psychiatry and the Law. 2012; 40:59–66. [PubMed: 22396343]

Carr GD. Professional sexual misconduct—An overview. Journal of the Mississippi State Medical Association. 2003; 44(9):283–300. [PubMed: 14564742]

Centers for Disease Control and Prevention. Sexual violence: Consequences. 2016. Retrieved from http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html

Corbin, J., Strauss, A. Basics of qualitative research: Techniques and procedures for developing grounded theory. Los Angeles, CA: Sage; 2014.

DuBois JM, Anderson EE, Carroll K, Gibb T, Kraus E, Rubbelke T, … Vasher M. Environmental factors contributing to wrongdoing in medicine: A criterion-based review studies and cases. Ethics & Behavior. 2012; 22:163–188. [PubMed: 23226933]

DuBois JM, Anderson EE, Chibnall J, Carroll K, Gibb T, Ogbuka C, … Rubbelke T. Understanding research misconduct: A comparative analysis of 120 cases of professional wrongdoing. Accountability in Research. 2013; 20:320–338. DOI: 10.1080/08989621.2013.822248 [PubMed: 24028480]

DuBois JM, Chibnall JT, Anderson EE, Eggers M, Baldwin K, Vasher M. A mixed-method analysis of reports on 100 cases of improper prescribing of controlled substances. Journal of Drug Issues. 2016; 46:457–472. DOI: 10.1177/0022042616661836 [PubMed: 28663601]

DuBois JM, Kraus E, Vasher M. The development of a taxonomy of wrongdoing in medical practice and research. American Journal of Preventive Medicine. 2012; 42:89–98. DOI: 10.1016/j.amepre.2011.08.027 [PubMed: 22176853]

Elman C. Explanatory typologies in qualitative studies of international politics. International Organization. 2005; 59:293–326. DOI: 10.1017/s0020818305050101

Ernsthausen, J. Dangerous doctors, flawed data. The Atlanta Journal-Constitution. 2016. Jul 6. Retrieved from http://doctors.ajc.com/sex_abuse_national_database/?ecmp=doctorssexabuse_microsite_nav

Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. The Lancet. 2002; 359:545–550.

Federation of State Medical Boards. Addressing sexual boundaries: Guidelines for state medical boards. Washington, DC: Author; 2010.

Federation of State Medical Boards. US medical regulatory trends and actions. Washington, DC: Author; 2014.

George, A., Bennett, A. Case studies and theory development in the social sciences. Cambridge, MA: MIT Press; 2005.

Grant D, Alfred KC. Sanctions and recidivism: An evaluation of physician discipline by state medical boards. Journal of Health Politics, Policy and Law. 2007; 32:867–885. DOI: 10.1215/03616878-2007-033

Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. Field Methods. 2006; 18:59–82.

Hart, A. Which doctors are sexually abusive?. The Atlanta Journal-Constitution. 2016. Jul 6. Retrieved from http://doctors.ajc.com/doctors_who_sexually_abuse/?ecmp=doctorssexabuse_microsite_nav

Hennink, M., Hutter, I., Bailey, A. Qualitative research methods. Thousand Oaks, CA: Sage; 2011.

Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Academic Medicine. 2007; 82:1040–1048. [PubMed: 17971689]

Jones CA. A reason to doubt: The suppression of evidence and the inference of innocence. Journal of Criminal Law and Criminology. 2010; 100:415–474.

Leonard DP. Character and motive in evidence law. Loyola of Los Angeles Law Review. 2001; 34:439–536.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

MacDonald K, Sciolla AF, Folsom D, Bazzo D, Searles C, Moutier C, … Norcross WA. Individual risk factors for physician boundary violations: The role of attachment style, childhood trauma and maladaptive beliefs. General Hospital Psychiatry. 2015; 37:489–496. [PubMed: 26554082]

Maguire, M., Reiner, R., Morgan, R. The Oxford handbook of criminology. New York, NY: Oxford University Press; 2007.

Namey, E., Guest, G., Thairu, L., Johnson, L. Data reduction techniques for large quantitative data sets. In: Guest, G., Macqueen, KA., editors. Handbook for team-based qualitative research. New York, NY: Altamira Press; 2008. p. 137-161.

Norder, L., Ernsthausen, J., Robbins, D. Why sexual misconduct is difficult to uncover. The Atlanta Journal-Constitution. 2016. Jul 6. Retrieved from http://doctors.ajc.com/sex_abuse_numbers/

Papadakis MA, Arnold GK, Blank LL, Holmboe ES, Lipner RS. Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. Annals of Internal Medicine. 2008; 148:869–876. [PubMed: 18519932]

Papadakis MA, Paauw DS, Hafferty FW, Shapiro J, Byyny RL. Alpha Omega Alpha Honor Medical Society Think Tank. Perspective: The education community must develop best practices informed by evidence-based research to remediate lapses of professionalism. Academic Medicine. 2012; 87:1694–1698. DOI: 10.1097/ACM.0b013e318271bc0b [PubMed: 23095921]

Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, … Hodgson CS. Disciplinary action by medical boards and prior behavior in medical school. New England Journal of Medicine. 2005; 353:2673–2682. DOI: 10.1056/NEJMsa052596 [PubMed: 16371633]

Ragin CC, Shulman D, Weinberg A, Gran B. Complexity, generality, and qualitative comparative analysis. Field Methods. 2003; 15:323–340. DOI: 10.1177/1525822x03257689

Roller, MR., Lavrakas, PJ. Applied qualitative research design: A total quality framework approach. New York, NY: Guilford Press; 2015.

Sansone RA, Sansone LA. Crossing the line: Sexual boundary violations by physicians. Psychiatry. 2009; 6(6):45–48.

Silva, CN. Ex post facto studies. In: Salkind, NJ., editor. Encyclopedia of research design. Vol. 1. Thousand Oaks, CA: Sage; 2010. p. 465-466.

Simonton DK. Qualitative and quantitative analyses of historical data. Annual Review of Psychology. 2003; 54:617–640. DOI: 10.1146/annurev.psych.54.101601.145034

Spickard WA Jr, Swiggart WH, Manley GT, Samenow CP, Dodd DT. A continuing medical education approach to improve sexual boundaries of physicians. Bulletin of the Menninger Clinic. 2008; 72:38–53. [PubMed: 18419243]

Swiggart WH, Dewey CM, Ghulyan MV, Spickard A. Spanning a decade of physician boundary violations: Are we improving? HEC Forum. 2016; 28(2):129–140. DOI: 10.1007/s10730-015-9282-8 [PubMed: 26013843]

Teegardin, C., Robbins, D., Ernsthausen, J., Hart, A. License to betray. The Atlanta Journal-Constitution. 2016. Jul 6. Retrieved from http://doctors.ajc.com/doctors_sex_abuse/?ecmp=doctorssexabuse_microsite_nav

Teherani A, Hodgson CS, Banach M, Papadakis MA. Domains of unprofessional behavior during medical school associated with future disciplinary action by a state medical board. Academic Medicine. 2005; 80(Suppl 10):S17–S20. [PubMed: 16199450]

Tillinghast E, Cournos F. Assessing the risk of recidivism in physicians with histories of sexual misconduct. Journal of Forensic Sciences. 2000; 45:1184–1189. [PubMed: 11110167]

Tracy, C., Fromson, T., Long, J., Whitman, C. Rape and sexual assault in the legal system. Paper commissioned by the National Research Council Panel on Measuring Rape and Sexual Assault in the Bureau of Justice Statistics Household Surveys. 2012. Jun 5. Retrieved from http://jpp.whs.mil/Public/docs/04-Meetings/sub-20150507/03_Rape_SexAsslt_LegalSystem_WLP_AEQuitas_20120605.pdf

United States Conference of Catholic Bishops. Charter for the protection of children and young people. Washington, DC: 2001. Retrieved from http://www.usccb.org/issues-and-action/child-and-youth-protection/upload/2011-Charter-booklet.pdf

U.S. Department of Health and Human Services. NPDB guidebook. Rockville, MD: Author; 2015.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

U.S. Department of Justice. Criminal justice information services (CJIS) division uniform crime reporting (UCR) program: Reporting Rape in, 2013. Washington, DC: Federal Bureau of Investigation, U.S. Department of Justice; 2014.

U.S. Department of Justice. Special report: Female victims of sexual violence, 1994–2010 (NCJ 240655). Washington, DC: Author; 2016.

Vogt, PW., Vogt, ER., Gardner, DC., Haeffele, LM. Selecting the right analyses for your data: Quantitative, qualitative, and mixed methods. New York, NY: Guilford Press; 2014.

Walzer R, Miltimore S. Protoctoring disciplined providers. Journal of Medical Licensure and Discipline. 1994; 81(2):79–95.

Young A, Chaudhry H, Pei X, Halbesleben K, Polk DH, Dugan M. A census of actively licensed physicians in the United States, 2014. Journal of Medical Regulation. 2015; 101(2):8–23.

Young A, Chaudhry HJ, Rhyne J, Dugan M. A census of actively licensed physicians in the United States, 2010. Journal of Medical Regulation. 2011; 96(4):10–20.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 1

Primary Form of Sexual Abuse With Accompanying Violations.

Primary form of abuse (n)	Touching/comments	Consensual sex	Other sexual offense	Interprofessional relationships	Fraud	Improper prescribing	Other illegal behavior
Consensual sex only (7)	0%	100%	14.3%	14.3%	0%	14.3%	28.6%
Touching/comments only (33)	100%	6.1%	6.1%	12.1%	6.1%	30.3%	12.1%
Child molestation (14)	100%	14.3%	42.9%	14.3%	7.1%	28.6%	42.9%
Sodomy (31)	93.5%	9.7%	19.4%	12.9%	9.7%	12.9%	12.9%
Rape (16)	87.5%	25.0%	12.5%	12.5%	25.0%	56.3%	25.0%
Cramer's V(p)	.78 (<.001)[a]	.20(.26)[b]	.31 (.04)	.02 (1.00)	.23 (.24)	.33 (.03)	.27 (.11)

Note. "Primary Form of Abuse" represents the *primary* (main) form of sexual abuse perpetrated by the physician; "Accompanying Violations" refer to other forms of abuse or misconduct engaged in by physicians with a given primary form of abuse; for example, consensual sex was the *primary* form of sexual abuse for seven physicians; among those seven, one physician (14.3% of seven) also engaged in an "Other Sexual Offense," and so forth. We combined offenses that involved inappropriate comments with inappropriate touching. These cases always involved inappropriate touching; in some instances, they also involved inappropriate comments. We defined "rape" as penetration of the mouth, anus, or vagina by a penis without consent, and "sodomy" as penetration of the anus or vagina by anything other than a penis without consent. "Other Sexual Offense" includes exhibitionism, voyeurism, showing pornography to patients, and stalking. "Other illegal" primarily involves arrests for child pornography in child molestation cases, driving under the influence and improper prescribing among physicians engaging in consensual sex, and rape of nonpatients or improper prescribing among physicians engaging in rape. "Inter-professional relationships" refers to inappropriate relationships with colleagues—for example, sexual harassment of a nurse. Significant differences in the rates of accompanying violations across kinds of sexual offenses are indicated in boldface.

[a] Excludes the "touching/comments only" cell.

[b] Excludes "consensual sex only" cell.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 2

Frequency of Case Attributes (N= 101).

Workplace		Case characteristics	
Nonacademic, private practice	94.1%	Accomplice involved	1.0%
Physician practice size		Professional wrongdoing > 1 type	88.1%
Solo	38.6%	Wrongdoing in >1 environment	24.8%
Small	6.9%	Repeated sexual abuse	96.0%
Large	41.6%	Duration of abuse in main workplace	
Other/unknown	12.9%	<1 year	26.7%
Physician ownership		1 to <2 years	14.9%
Solo	38.6%	2 to <5 years	27.7%
Joint	2.0%	5 + years	30.7%
Employee	49.5%	Patients always examined alone	85.1%
Other/unknown	9.9%	Missed opportunity to blow whistle	26.7%
Abuser description		Whistle-blower ignored	16.8%
Age > 39 years	92.1%	Whistle-blower relationship to abuser	
Gender: Male	100%	Patient	69.3%
Born outside the United States	15.8%	Peer/physician colleague	3.0%
Trained outside the United States	25.7%	Nurse or other staff	4.0%
Specialty		Other/unknown	17.8%
Internal/general	14.9%	Investigation	
OB-GYN	12.9%	Board investigation	94.1%
Psychiatry/neurology	16.8%	Criminal investigation	89.1%
Pediatrics/family	39.6%	Civil proceedings	48.5%
Other	15.9%	Others were found guilty	2.0%
Board certified	30.7%	Consequences	
Literature mentions some personality traits (personality)	31.7%	Loss of licensure	87.1%
		Financial penalties	43.6%
Evidence of severe mental illness	3.0%	Prison, criminal probation or service	54.5%
Substance addiction	5.0%	Mandated treatment or education	29.7%
Significant personal problems	6.9%	Discontinued practicing medicine	74.3%
Poor professional skills/performance	6.9%	Loss of job/professional opportunities	98.0%
Victim characteristics		Increased oversight/monitoring	34.7%
Number of victims: 5+	57.4%		
Patient-victim age			
Adult	60.4%		
Senior	1.0%		
Child	9.9%		
General	28.7%		
Women	89.1%		
Racial minority	1.0%		

Note. OB-GYN = obstetrics-gynecology.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 3

Primary Form of Sexual Abuse With Physician and Environmental Characteristics.

Primary form of abuse (*n*)	Solo practice	Lack of oversight	Oversight failure	Vulnerable patients	Personality	Board certified	Male
Consensual sex only (7)	28.6%	100%	0%	28.6%	14.3%	71.4%	100%
Touching/comments only (33)	48.5%	78.8%	9.1%	18.2%	27.3%	39.4%	100%
Child molestation (14)	42.9%	85.7%	7.1%	100%	28.6%	28.6%	100%
Sodomy (31)	25.8%	80.6%	3.2%	16.1%	12.9%	19.4%	100%
Rape (16)	43.8%	100%	0%	37.5%	81.3%	18.8%	100%
Cramer's V (p)	.20 (.39)	.23 (.23)	.16 (.60)	**.60 (<.001)**	**.50 (<.001)**	**.31 (.048)**	—

Note. We combined offenses that involved inappropriate comments with inappropriate touching. These cases always involved inappropriate touching; in some instances, they also involved inappropriate comments. We defined "rape" as penetration of the mouth, anus, or vagina by a penis without consent, and "sodomy" as penetration of the anus or vagina by anything other than a penis without consent. "Lack of oversight" means that in no instances was another person in the room when the event occurred. "Personality" means the literature referenced at least two characteristics indicative of antisocial personality. All patients are vulnerable; we labeled patients as "especially vulnerable" when they belong to a protected class (e.g., minors or older adults) or exhibited cognitive impairments (e.g., due to anesthesia or severe mental illness). Significant differences in the rates of physician/environmental variables across kinds of sexual offenses are indicated in boldface.

QUESTIONABLE DOCTORS

NEGLIGENT DOCTORS AND THE FAILURE OF NEW YORK STATE TO NOTIFY PATIENTS

ENDORSED BY:

CENTER FOR JUSTICE & DEMOCRACY
CENTER FOR MEDICAL CONSUMERS
COMMISSION ON THE PUBLIC'S HEALTH SYSTEM
CONSUMERS UNION
EMPIRE STATE CONSUMER PROJECT
NEW YORKERS FOR PATIENT & FAMILY EMPOWERMENT
NEW YORK PUBLIC INTEREST RESEARCH GROUP (NYPIRG)
PEGGY LILLIS FOUNDATION
PULSE OF NEW YORK

MAY 2014

Acknowledgements

Written by Blair Horner and Casey Ciceron of the New York Public Interest Research Group Fund and Arthur Levin of the Center for Medical Consumers. The authors thank Suzanne Mattei of New Yorkers for Patient & Family Empowerment for her significant contributions.

The **Center for Medical Consumers**, a non-profit advocacy organization, was founded in 1976 with this philosophy: Whenever long-term drug therapy, elective surgery, or any other major treatment is prescribed, the question of whether the treatment has been proven safe and effective should come up. And the prescribing physician should be expected to cite the relevant studies. Toward this goal, CMC:

- participates in nationwide and statewide efforts to reduce medical errors;
- encourages public access to information about the comparative performance of doctors and hospitals.
- works with policy makers to strengthen the process by which physicians and other health professionals are licensed and disciplined;
- represents patients and consumers on national committees working to develop health care performance measures;
- works with other advocacy organizations to increase patient and family engagement in health information technology.
- and supports New York State's efforts to transform the paper-based medical record system to a digital system that will enhance communication between patients and health care providers.

New Yorkers for Patient & Family Empowerment (also known as "Patient & Family") is a not-for-profit organization that seeks to:

(1) Empower patients and their loved ones in interacting with the healthcare system;
(2) Strengthen public access to information on patient safety; and
(3) Improve the quality and safety of healthcare in New York.

We define "family" to include the key support persons and loved ones in the patient's life, as determined by the patient.

The **New York Public Interest Research Group Fund** (NYPIRG) is a nonpartisan, not-for-profit organization whose mission is to affect policy reforms while training New Yorkers to be citizen advocates. NYPIRG's full-time staff works with citizens, produces studies on a wide array of topics, coordinates state campaigns, engages in public education efforts and lobbies public officials.

© 2014, NYPIRG

You can download the report by going to the NYPIRG website:

www.nypirg.org

QUESTIONABLE DOCTORS:
NEGLIGENT DOCTORS AND THE FAILURE OF NEW YORK STATE TO NOTIFY PATIENTS
SUMMARY

Thousands of New Yorkers are harmed by mistakes made by their medical providers each year. One of the first lines of defense in protecting patients is the state's system of overseeing physician conduct. This report identifies shortfalls in New York's doctor discipline system and how proposed reforms could help protect patients from questionable doctors.

The New York State Department of Health's Office of Professional Medical Conduct (OPMC) is the agency charged with protecting patients. This report reviews its work over the past ten years. *One important note about this report:* The vast majority of New York's doctors are caring and competent. This report is focused on the state's program to ensure that those few doctors whose skills are questionable are identified and, if necessary, to protect patients removed from practice.

SUMMARY OF FINDINGS

Finding: Over 77% of doctors sanctioned for negligence by OPMC were allowed to continue to practice. It is highly likely that the patients of physicians who have been sanctioned for negligence would want to know this information. However, it is highly *unlikely* that these patients are aware of their physician's punishment.

Finding: Nearly 60% of New York State actions against doctors were based on sanctions taken by other states, the federal government, or the courts, not directly as the result of an OPMC-initiated investigation. The OPMC database includes information about physicians that were not disciplinary in nature. When excluding those statistics from our analysis, about 60% of OPMC sanctions were based on findings of other enforcement agencies (other states, or the courts). While it is important that the OPMC act when another agency has punished a physician, it is the more critical task of identifying and punishing misconduct by doctors who are currently active in New York State that must occupy the attention of OPMC investigators. Health care providers are generating few of these complaints.

Finding: There has been a staggering increase in the number of doctors per capita in New York State, well in excess of the increase in the state's population. One of the arguments as to why New York State does not revoke questionable doctors' licenses is that they are an important resource. However, over the past ten years, New York's population has grown by about 2%. Its doctor population has swelled by 36%.

Finding: The Health Department has failed to update its "annual report" on OPMC's physician discipline activities. The most recent report, for 2010, shows that very few complaints originate from those who are among the most likely to observe misconduct – other physicians. Moreover, the information published in this now out-of-date report masks OPMC's activity level of aggregating sanctions stemming from its

own direct investigations as well as actions based on the investigations of other states or entities. Thus, members of the public would likely infer incorrectly that OPMC is engaging in a higher level of in-state oversight than actually is occurring.

SUMMARY OF RECOMMENDATIONS

Policymakers must make protecting patient safety their number one priority. This report identifies serious shortcomings in the state's oversight of doctors. While additional resources are clearly needed, other common-sense reforms would help bolster patient protection.

- **Require that all licensed health facilities and physicians' offices post information on how patients and other members of the public can access the physician profiles program.** The public should have easy access to physicians' background information. Such a requirement would allow consumers to have access to the website that would allow them to file a complaint against a doctor or other relevant health provider (http://www.health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm), ensure that patients are aware of the state's physician profiles (www.nydoctorprofile.com), and provide access to the OPMC database of its actions against doctors and other providers (http://www.health.state.ny.us/nysdoh/opmc/main.htm). **In addition, all patients of physicians who have had any limitation placed on their license must be notified in a timely manner.**

- **Create an OPMC consumer assistance office.** A consumer-friendly office should be created to help consumers navigate the complaint process, better understand when a complaint is appropriate for OPMC and, if not, redirect inquiries to other relevant agencies.

- **Require health care providers who harm patients as a result of a medical mistake to tell the patient or patient's family when such a mistake occurs.** Physicians are required by their own code of ethics to report medical mistakes even if such admission exposes them to liability.[1] The force of law should back up this common sense ethical requirement by ensuring that failure to do so constitute misconduct.

- **Require periodic recertification of physicians to include assessment of competency.** Over time, physicians may see some of their skills erode and it is critically important for them to keep current with the latest medical research and advances in technology. In an effort to identify physicians with eroding skills or knowledge deficiencies before a patient gets harmed, routine periodic evaluation of competency should be required as a condition of continued licensure and recertification.

---

[1] American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, E-8.12 "Patient Information," see: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion812.page?

THE PROBLEM -- MEDICAL ERRORS

As the chart below shows, patient deaths resulting from medical mistakes in hospitals are either the third or fourth leading cause of death in America.[2]

LEADING CAUSES OF DEATH IN AMERICA[3]

Cause of death	Number of deaths
Disease of the heart	596,339
Malignant neoplasms (cancer)	575,313
Hospital deaths due to medical errors (high estimate)	*400,000*
Hospital deaths due to medical errors (low estimate)	*210,000*
Chronic lower respiratory diseases	143,382
Cerebrovascular diseases	128,931
Accidents (unintentional injuries)	122,777
Alzheimer's disease	84,691
Diabetes mellitus	73,282
Influenza and pneumonia	53,667
Nephritis, nephrotic symptoms and nephrosis	45,731

The findings of this report build on previous studies that estimated huge numbers of patient injuries and deaths due to medical errors. Most notably, the National Academy of Sciences' Institute of Medicine's (IoM) report, *To Err Is Human*,[4] noted that estimates of injury and cost are considered by many experts to be low because these types of reports do not look at medical errors occurring outside of hospitals; for example, in outpatient clinics, physicians' offices and retail pharmacies. Nonetheless, the numbers are staggering. The IoM called for sweeping changes in order to substantially reduce the number of medical errors. Improving patient safety is where policy makers must place their focus.

New York State Health Department's Response

Soon after the Institute of Medicine called for a 50% reduction of medical errors by within five years, the then-New York State Health Commissioner pledged to meet the IoM goal.[5]

[2] James, J., "A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care," *J Patient Safety*, 9(3):122-128 (Sept. 2013).

[3] U.S. Centers for Disease Control and Prevention, National Vital Statistics Reports, Vol. 61, No. 6, October 10, 2012. Hospital patient death estimates from the Journal for Patient Safety, Ibid.

[4] National Academy of Sciences' Institute of Medicine, "To Err is Human: Building A Better Health Care System," November 1999.

[5] New York State Health Department, "NYPORTS News & Alert," Issue No. 14, January 2004.

State government is traditionally charged with licensing and monitoring the conduct of health care professionals. In New York State the first line of defense in assuring that misconduct by physicians and physician assistants is investigated and, when appropriate, punished, is the Health Department's Office of Professional Medical Conduct (OPMC).

The vast majority of physicians in New York State practice medicine that meets the high standards of professional conduct. However, those who are engage in misconduct can cause enormous pain and suffering for their patients. Because it is the licensing authority, the state must act forcefully and quickly to minimize the harm to patients that often result from professional misconduct.

THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT

There are 102,554 physicians licensed to practice in New York State, of which 83,287 live within the state.[6] Physicians currently practicing out of state, or otherwise not in active practice in New York, must keep their New York license current by paying the $575 biennial fee – a requirement common in other professions.[7]

The OPMC is charged with responding to complaints and monitoring physicians and physician assistants and taking action when professionals are found to pose a threat to the public because of their misconduct. It employs a staff of investigators and prosecutors to investigate complaints and file charges. The Board of Professional Medical Conduct (BPMC) is responsible for hearing cases and taking action against licensees after they have been formally charged by the OPMC. The Board is comprised of 144 members that are available to hear cases against physicians in the presence of an administrative law judge. Usually a three-member BPMC panel – two physicians and one "public" member – sit to hear the case and decide the punishment.[8]

This analysis reviews the OPMC's track record over past decade to examine how well it is monitoring and, if appropriate, punishing substandard doctors. We reviewed the state's existing database of actions on the Department's website. Below are the results of our analysis.

---

[6] New York State Education Department, see: http://www.op.nysed.gov/prof/med/medcounts.htm.
[7] New York State Education Law, Section 6524 (8).
[8] New York State Department of Health, "Board for Professional Medical Conduct, 2010," see: http://www.health.ny.gov/professionals/doctors/conduct/annual_reports/2010/.

Review of New York State Department of Health's Office of Professional Medical Conduct; Physician Discipline Actions Taken, 2004-2013[9]

Year	Relied on out of state action	Relied on other entity	No disciplinary action by DOH	DOH acts; loss of license	Total Actions Listed	Total NY Actions Only[10]	Negligence Found[11]	Negligence in which license is lost[12]
2004	141	18	31	39	342	152	58	13
2005	160	16	38	41	337	123	59	13
2006	172	22	43	32	336	99	40	18
2007	127	18	47	50	323	131	34	12
2008	118	25	64	41	315	108	47	18
2009	92	35	57	34	291	107	43	18
2010	129	35	48	23	326	114	41	10
2011	137	35	48	19	309	89	42	7
2012	131	35	50	34	313	97	39	11
2013	186	47	77	36	468	158	59	14

A closer examination of this data and trends follows.

---

[9] New York State Department of Health, Professional Medical Board Actions Since 1990, accessed on February 1, 2014, see: https://health.data.ny.gov/Health/Professional-Medical-Conduct-Board-Actions-Beginni/ebmi-8ctw. As mentioned, this analysis only examined the years 2004 through the end of 2013.

[10] Calculation by authors. It is the product of the combined number of actions in which the New York State Department of Health relied on actions in other states, actions taken by other in-state entities (usually NYS courts) and cases in which the Department declared were not disciplinary actions or not new disciplinary actions, and then subtracted from the total number of physician disciplinary actions.

[11] The Department of Health states:

> Examples of medical misconduct include (but are not limited to): practicing fraudulently, practicing with gross incompetence or gross negligence; practicing while impaired by alcohol, drugs, physical or mental disability; being convicted of a crime; filing a false report; guaranteeing that treatment will result in a cure; refusing to provide services because of race, creed, color or national origin; performing services not authorized by the patient; harassing, abusing or intimidating a patient; ordering excessive tests; and abandoning or neglecting a patient in need of immediate care.

Medical negligence -- the improper, unskilled, careless or negligent treatment of a patient by a healthcare professional -- can take many forms. Obvious examples are wrong-sided surgery, wrong patient surgery, or substandard care that results in a harmful infection. It can also include the failure to diagnose a condition because the medical professional jumps to a conclusion based on a preconceived notion rather than conducting proper tests to eliminate important possibilities. Elderly patients and people with disabilities often have to struggle to get proper attention paid to their ailments, and studies have also raised concerns about disparities in care based on race or ethnicity, gender, gender orientation, and weight.

The impact of substandard care can be devastating for the patient and for the patient's loved ones. Those who survive medical negligence may be forced to live with chronic pain or substantial loss of abilities, affecting both their economic welfare and their home life. The consequences of medical negligence therefore have an impact on the community, worsening disparities in our society. Preventing this harm should be a primary imperative in New York.

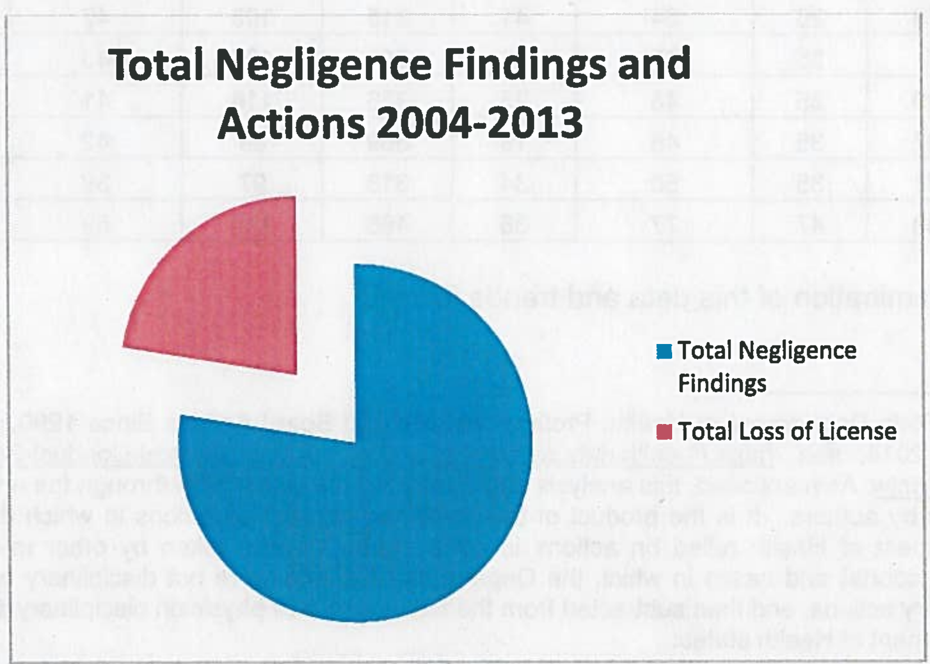
http://www.health.ny.gov/professionals/doctors/conduct/frequently_asked_questions.htm#misconduct.

[12] For the purposes of this analysis, we defined "loss of license" to mean a suspension of more than 30 days, or a surrender or revocation of a physician's license.

FINDING: IN CASES IN WHICH THE OPMC FOUND NEGLIGENCE ON THE PART OF THE DOCTOR, 77 % ALLOWED TO PRACTICE

AND HALF OF OPMC SANCTIONS WERE BASED ON ACTIONS TAKEN BY OTHER AGENCIES

In cases where the OPMC found evidence of negligence on the part of the provider, an overwhelming majority continued to practice. As seen below, over 77% of physicians who were found to have practiced negligently were allowed to continue to practice.

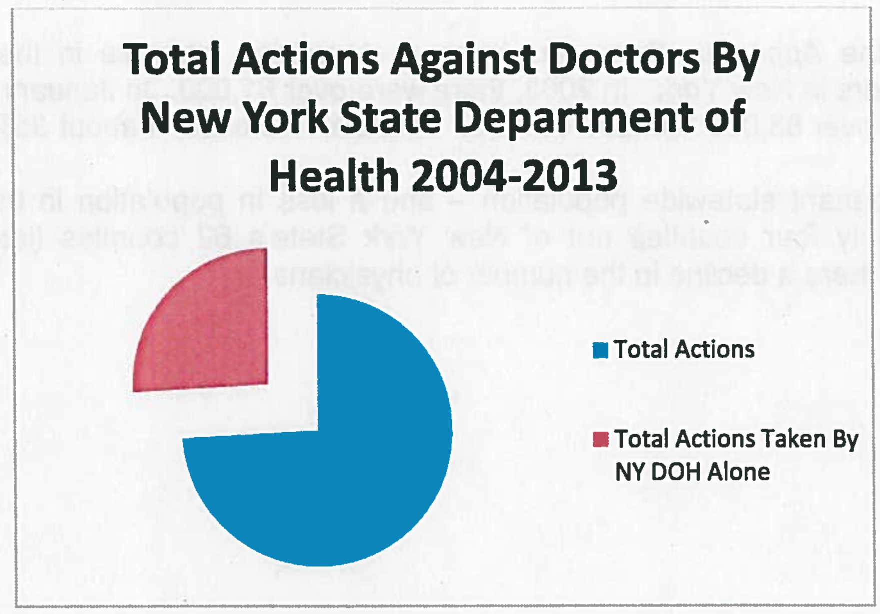


It is highly likely that the patients of physicians who have been guilty of negligence would want to know this information. However, it is highly unlikely that these physicians' patients are aware of their physician's punishment. A patient can only find out about such a disciplinary action if: (1) they know how to access this information through the Health Department's web-sites[13] or 800 hot line number; and, (2) they take the initiative to do so. There is at present no requirement that patients be informed that their physician is practicing under sanction and/or limitations.

[13] Address for the website is: www.health.state.ny.us/nysdoh/opmc/main.htm. Disciplinary and other information about physicians can also be found at www.nydoctorprofile.com.

Nearly 60% of New York State actions against doctors were based on sanctions taken by other states, the federal government, or the courts, not directly as the result of an OPMC-initiated investigation. The OPMC database includes information about physicians that were not disciplinary in nature. When excluding those statistics from our analysis, about 60% of OPMC sanctions were based on findings of other enforcement agencies (other states, or the courts).

While no one would argue that OPMC should *not* be taking actions against substandard out-of-state doctors, the proportion of in-state actions should be higher given the magnitude of the injuries and deaths caused by incompetent physicians. Moreover, the OPMC's annual report hides this distinction by aggregating all actions it takes – combining both in and out of state – into one category. The public and policymakers should demand more detailed disclosure by OPMC.



FINDING: THE NUMBER OF NEW YORK STATE DOCTORS HAS INCREASED AT A RATE FAR BEYOND THE INCREASE IN THE OVERALL STATE POPULATION

One often heard defense for allowing substandard physicians to continue to practice is the assertion that medical professionals are a scarce community resource, and that reducing their numbers would put public health at risk.

Nothing could be further from the truth.

According to the U.S. Census, in 2013 it estimated that New York State had 19.6 million residents.[14] The Department of Health has estimated that the state had 19.2 million residents in 2004. Thus, the state's population has increased slightly, around a 2% increase.

As seen in the *Appendix*, there has been a staggering increase in the number of licensed doctors in New York. In 2003, there were over 61,000. In January of this year, the state had over 83,000 licensed doctors. That's an increase of about *36%*.

Despite a stagnant statewide population – and a loss in population in many upstate areas – in only four counties out of New York State's 62 counties (less than one percent) was there a decline in the number of physicians.

---

[14] Source for 2013 New York State population estimate: U.S. Census Bureau, "State and County Quickfacts: New York" http://quickfacts.census.gov/qfd/states/36000.html. Source for 2004 population estimate: New York State Department of Health, "Table 1: Estimated Population by Sex, Age and Region," http://www.health.ny.gov/statistics/vital_statistics/2004/table01.htm.

FINDING: THE HEALTH DEPARTMENT HAS FAILED TO UPDATE ITS ANNUAL REPORT ON OPMC ACTIVITIES. THE MOST RECENT, FOR 2010, SHOWS THAT VERY FEW COMPLAINTS ORIGINATE FROM THOSE MOST LIKELY TO OBSERVE MISCONDUCT – OTHER PHYSICIANS.

While the number of actions has declined, with a larger decrease last year, it is clear that there has not been a reduction in complaints. As the chart below shows, for the period 2000 through 2010[15] (the most recent year), the number of complaints against doctors has increased dramatically. Interestingly, those most likely to have observed medical mistakes – other health care professionals and the institutions in which they worked – are by far the least likely to file complaints. The state should consider how to better enforce the requirement that professionals and organizations report misconduct.

Year	Total Complaints	Public	Gov't Agency	Out of State	Insurers	Physicians	Hospital/ Health Facility	Other	Medical malpractice	Physician profile
2010	8,501	51%	17%	9%	3%	6% (providers)		0.2%	13%	1%
2009	9,134									
2008	8,921									
2007	8,222									
2006	8,001									
2005	7,358	58%	15%	14%	8%	2%	N/A	3%		
2004*	6,925	58%	15%	12%	9%	2%	N/A	4%		
2003*	6,275	*	*	*	*	*	*	*		
2002*	7,295	*	*	*	*	*	*	*		
2001	6,983	55%	16%	10%	11%	2%	N/A	6%		
2000	6,106	61%	11%	11%	10%	3%	3%	1%		

In its most recent annual report – for the year 2010 – the Department identified trends:

- The Board imposed 307 final actions, the highest since 2006. Of those, 59% (182) included the loss, suspension, or restriction of a physician's medical license.
- 8,501 complaints were received, 24% higher than five years ago. The Office reviewed and closed 9,108 complaints, the 2nd highest in a decade.
- The Office closed 4,024 investigations, the 2nd highest ever and referred 322 physicians for charges of misconduct. Despite challenges faced due to the State's fiscal crisis, the average time to complete an investigation remains about nine months, consistent with completion time in 2008 and 2009.
- The average number of investigations completed per investigator increased from 35 in 2009 to 47, a 34% increase, resulting from improved training, management and monitoring initiatives implemented by the program.
- New criteria to commence an investigation based on medical malpractice information were implemented, improving the use of this information as a predictor of possible misconduct.

However, in its statistical analysis, the Department fails to disaggregate OPMC actions, such as is done in this report. Thus, members of the public who wished to evaluate OPMC's performance would see an inflated – and an obviously out-of-date – number of actions.

[15] New York State Department of Health, accessed on May 10, 2014. See: http://www.health.ny.gov/professionals/doctors/conduct/annual_reports/.

BACKGROUND: TOO FEW PHYSICIANS ARE BEING DISCIPLINED AND NOT ENOUGH ARE BEING SANCTIONED FOR JEOPARDIZING PATIENT HEALTH AS A RESULT OF POOR QUALITY MEDICAL CARE.

Very few of New York State's doctors ever face a serious disciplinary action. The 468 completed actions taken by OPMC in 2013 must be judged in light of the staggering number of patients harmed by negligent medical care annually. As mentioned earlier, the recent estimate of hospital patient injuries range nationally from a low of 210,000 to 400,000. Since New York State's population is roughly 6.7% of the nation's, a rough estimate of patients killed in New York hospitals ranges from a low of 14,000 to a high of 26,000 each year – or 38 to 73 patients killed each day!

Studies have shown that when these estimates are expanded to include general medical practice outside of the hospital, the potential harm by physicians is even greater. According to researchers who published their findings in *The Journal of Family Practice*, an "in-depth interview with 53 family physicians revealed that 47% of the doctors recalled a case in which the patient died due to physician error. Only four of the total reported errors led to malpractice suits, and none of these errors resulted in an action by a peer review organization."[16]

In addition, a Florida study documented unnecessary injuries occurring in physicians' offices. According to the study of surgical errors in physicians' offices, patients were ten times more likely to be harmed due to medical errors than when they had the same surgery in more highly regulated health care facilities.[17]

Given the magnitude of medical negligence, we believe there should be more actions taken against incompetent physicians. According to Public Citizen Health Research Group, "It is not unreasonable to estimate that at least 1% of doctors in this country deserve some serious disciplinary action each year."[18] Using Public Citizen's estimate, the OPMC should have disciplined ***at least 1,026 physicians last year***.

Public Citizen's estimate was derived from the analysis of studies published by Tufts University and the AMA. In fact, the Tufts study shows that the Public Citizen estimate may be a conservative one. According to that study, "physician-owned malpractice insurers sanctioned 13.6 of every 1,000 doctors they covered."[19]

---

[16] Wolfe, S., M.D. *et al.* "Questionable Doctors Disciplined by State and Federal Governments," New York Edition, 1998, Public Citizen Health Research Group, p. 10.
[17] Vila, H., Soto, R., *et al.* "Comparative Outcomes Analysis of Procedures Performed in Physician Offices and Ambulatory Centers," *Arch Surg/Vol. 138, Sept. 2003,* p. 991.
[18] Wolfe, S. M.D. *et al.* "Questionable Doctors Disciplined by State and Federal Governments," New York edition. 1998, Public Citizen Health Research Group, p.12.
[19] Schwartz, W. *et al.* "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," *Journal of the American Medical Association*, 1989, 260(10), p. 1342-1346.

NEW YORK'S PATIENT SAFETY CENTER

In 2000, the creation of a Patient Safety Center was touted by then-Governor Pataki as an important patient safety measure.[20] Although originally envisioned to have other safety responsibilities, the Center was subsequently assigned to administer the newly created Physician Profile program, which permitted New Yorkers to easily access a doctor's background. Then-Governor Pataki and the Legislature supported physician profiles because, in the words of the Health Department:

> "Deaths can be avoided by providing patients with access to information that better informs them of physicians' education, training, credentials and experience and enables patients as consumers to actively participate in one of the most important health care decisions – the choice of physician. Immediate adoption of this rule is necessary in order to provide access to information, as well as timely reporting of updated or new information, which is of the utmost importance to consumers making decisions concerning access to high quality health care services."[21]

The profiling system requires physicians to self-report educational, board specialty, disciplinary, hospital credential and malpractice history, among other information. The inclusion of malpractice information – while publicly available at any courthouse – was vigorously opposed by the Medical Society of the State of New York. As part of the compromise that led to passage of the legislation, the profile system provides only limited malpractice information. Physicians only must post categorical information about the size of malpractice judgments or settlements and in the case of settlements, are only required to report any if they have paid three or more settlements over ten years. Information about the first and second settlement is not required to be posted on the profile unless the Commissioner deems it important for consumers to know of such payments. The Department has required that physicians report information on the first two settlements if the malpractice resulted in the "death or permanent injury" of the patient.[22]

[20] Then-Governor Pataki's comments on Patient Health Information and Quality Improvement Act of 2000, http://www.health.state.ny.us/nysdoh/healthinfo/pataki.htm.
[21] Title 10 NYCRR, Part 1000, "physician profiling."
[22] Title 10 NYCRR, Part 1000.3 (b)(2).

Policymakers must make protecting patient safety as their number one priority. This report identifies serious shortcomings in the state's oversight of doctors. While additional resources are clearly needed, other common sense reforms would help bolster patient protection:

- **Require that all health facilities and physicians' offices post information on how patients and other members of the public can access the physician profiles program.** The public should have easy access to physicians' background information. Such a requirement would allow consumers to have access to the website that would allow them to file a complaint against a doctor or other relevant health provider (http://www.health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm), ensure that patients are aware of the state's physician profiles resource (www.nydoctorprofiles.com), and provide access to the OPMC database of its actions against doctors and other providers (http://www.health.state.ny.us/nysdoh/opmc/main.htm). **In addition, all patients of physicians who have had any limitation on their license must be notified in a timely manner.**

- **Create an OPMC consumer assistance office.** A consumer-friendly office should be created to help consumers understand when a complaint is appropriate for OPMC, if not where else to seek redress, and to help them during the process, including communication as to the progress of the complaint.

- **Require health care providers who harm patients as a result of a medical mistake to tell the patient or patient's family when such a mistake occurs.** Physicians are required by their own code of ethics to report medical mistakes even if such admission exposes them to liability.[23] The force of law should back up this common sense ethical requirement.

- **Create a system of periodic recertification of physicians.** Both the IoM[24] and the State Health Department[25] have recommended that physicians be recertified to assure that they continue to practice as competent professionals. Over time, physicians may see some of their skills erode and it is increasingly hard but critically important for them to keep current with the latest medical research and advances in technology. In an effort to identify physicians with eroding skills before a patient gets harmed, a system of recertification based on evaluating competency should be required as a condition of continued licensure.

[23] American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, E-8.12 "Patient Information."
[24] National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.
[25] New York State Department of Health, Report of the New York State Advisory Committee on Physician Recredentialing: Phase One General Principles, Proposed Process, Recommendations, January 1988.

APPENDIX: COMPARISON OF THE NUMBERS OF DOCTORS PRACTICING, BY COUNTY, 1/1/2003-1/1/2014[26]

County	Number		County	Number		County	Number	
	2014	2003		**2014**	2003		**2014**	2003
Albany	**1,869**	1,388	Jefferson	**242**	203	Saratoga	**666**	308
Allegany	**42**	43	Kings	**6,322**	4,246	Schenectady	**472**	433
Bronx	**2,470**	1,795	Lewis	**33**	18	Schoharie	**20**	24
Broome	**651**	582	Livingston	**95**	54	Schuyler	**40**	24
Cattaraugus	**140**	117	Madison	**136**	104	Seneca	**23**	20
Cayuga	**109**	95	Monroe	**3,610**	2,620	Steuben	**239**	174
Chautauqua	**261**	208	Montgomery	**113**	81	St. Lawrence	**215**	166
Chemung	**307**	247	Nassau	**10,184**	7,831	Suffolk	**6,427**	3,976
Chenango	**74**	55	New York	**18,766**	13,954	Sullivan	**154**	93
Clinton	**253**	180	Niagara	**352**	256	Tioga	**54**	39
Columbia	**159**	113	Oneida	**639**	531	Tompkins	**343**	208
Cortland	**97**	58	Onondaga	**2,412**	1,644	Ulster	**405**	322
Delaware	**43**	49	Ontario	**326**	235	Warren	**284**	219
Dutchess	**1,259**	722	Orange	**1,272**	727	Washington	**63**	46
Erie	**3,650**	2,760	Orleans	**30**	32	Wayne	**92**	82
Essex	**89**	47	Oswego	**192**	105	Westchester	**6,951**	5,899
Franklin	**113**	94	Otsego	**348**	250	Wyoming	**49**	47
Fulton	**107**	66	Putnam	**294**	216	Yates	**37**	31
Genesee	**94**	72	Queens	**5,873**	4,450	**NYS TOTAL**	**83,287**	61,249
Greene	**70**	46	Rensselaer	**349**	261	**OTHER US**	**18,960**	13,286
Hamilton	**6**	3	Richmond	**1,889**	1,333	**NON-US**	**307**	235
Herkimer	**55**	51	Rockland	**1,358**	1,196	**TOTAL**	**102,554**	74,770

THE NUMBER OF NEW PHYSICIAN LICENSES ISSUED, 2004 THROUGH 2013[27]

	2004	**2005**	**2006**	**2007**	**2009**	**2010**	**2011**	**2012**	**2013**
Number of physicians	3,908	3,773	4,170	4,343	4,190	4,038	3,994	4,272	5,223

[26] New York State Education Department. Current year is available at: http://www.op.nysed.gov/prof/med/medcounts.htm. Location reflects the licensee's primary mailing address on record with the Office of the Professions; the address is not necessarily the licensee's practice address. Although licensees must be registered to use the professional title or to practice within New York State, being registered does not mean the licensee is actively doing so.
[27] *Ibid*, our data did not have the new physician licenses issued for 2008.

11 DUPONT CIRCLE NW
SUITE 800
WASHINGTON, DC 20036
202-588-5180
NWLC.ORG

Testimony of
Andrea Johnson, Senior Counsel for State Policy
National Women's Law Center
Before the New York State Legislature: Joint Hearing on Sexual Harassment

May 24, 2019

Thank you for the opportunity to submit this testimony on behalf of the National Women's Law Center. The National Women's Law Center has been working since 1972 to secure and defend women's legal rights and has long worked to remove barriers to equal treatment of women in the workplace, including harassment and other forms of discrimination.

Thank you for taking the time today to listen to survivors, working people, and advocates about the many ways in which our protections against workplace harassment need to be strengthened. In order to make meaningful, lasting change in response to the MeToo movement, it is absolutely crucial that survivors and workers, especially low-wage workers, women of color, immigrants, and LGBTQIA and gender nonconforming individuals who are most severely impacted by sexual violence, not just be heard, but be centered in the content and creation of these policies.

Legislators across the country are actively working to strengthen state anti-harassment and anti-discrimination laws. Last year, over 100 bills were introduced in state legislatures to strengthen protections against workplace harassment and by October 2018, 11 states had enacted some of these measures into law. At the beginning of 2019, over three hundred state legislators representing 40 states, including New York, signed a letter of commitment pledging to strengthen protections against sexual harassment and violence at work, in schools, homes, and communities in at least 20 states by 2020.[1]

New York has been a leader in raising awareness about and enacting long overdue policy reforms to stop and prevent workplace harassment. But while the legislature took important steps last year to strengthen anti-harassment protections, there remains much work to be done. Many of the protections enacted last year need to be strengthened and additional protections are needed to ensure access to justice, increase transparency and accountability, and incentivize meaningful prevention efforts.

For New York to remain a leader in fighting for workplace equality and against harassment, we urge you to consider the recommendations below.

I. WORKPLACE HARASSMENT REMAINS A SUBSTANTIAL BARRIER TO EQUALITY, DIGNITY, AND SAFETY AT WORK FOR NEW YORKERS.

Since #MeToo went viral nineteen months ago, increasing numbers of individuals who have experienced sexual harassment or assault at work have come forward to disclose their experiences. Many of these individuals remained silent for years because the risks of speaking

out were too high. With good reason, many feared losing their jobs or otherwise hurting their careers, feared not being believed, and feared that nothing would be done about the harassment. Moreover, the laws and systems in place designed to address harassment were inadequate to provide redress and justice, and instead subjected victims to additional devastating economic, physical, and psychological consequences, while protecting offenders.

Sexual harassment is a widespread problem, affecting workers in every state, in every kind of workplace setting and industry, and at every level of employment. In FY 2018, approximately 27,000 harassment charges were filed with the Equal Employment Opportunity Commission (EEOC); over one-quarter of those charges alleged sexual harassment—a 13.6 percent increase over the prior fiscal year.[2] The rates of workplace harassment, particularly sexual harassment, are likely much higher than the data suggests. Approximately three out of four individuals who experience harassment never talk to a supervisor, manager, or union representative about the harassing conduct.[3] Moreover, retaliation remains a significant problem, and continues to be the leading basis of charges filed with the EEOC.[4]

The Time's Up Legal Defense Fund, housed and administered by the National Women's Law Center Fund, was launched on January 1, 2018, and has received approximately 5,000 requests for assistance, with close to 400 requests from individuals in New York related to workplace sex discrimination.[5] The vast majority of these requests for help involved workplace sexual harassment and related retaliation. Over one-third of the requests from New York have been from workers in the arts and entertainment fields, health care, and education services. Significant numbers of individuals working in local government, information and communication, food services, and finance and insurance have also sought assistance. The majority of those who have reached out from New York have identified as low-income. The breakdown of these requests reflects reports in the media about persistent harassment in the entertainment and financial industries,[6] as well as our analysis of national EEOC data which shows that food services and health care are among the industries with the highest numbers of sexual harassment charges filed by women.[7]

II. KEY RECOMMENDATIONS FOR STRENGTHENING NEW YORK'S PROTECTIONS AGAINST WORKPLACE HARASSMENT AND DISCRIMINATION.

A. EXTEND RECENTLY ENACTED PROTECTIONS AGAINST SEXUAL HARASSMENT TO ALL FORMS OF HARASSMENT AND DISCRIMINATION.

While we commend the legislature for taking important steps last year to stop and prevent harassment by limiting the use of non-disclosure agreements (NDAs) and mandatory arbitration, mandating anti-harassment trainings, and extending protections to independent contractors, these protections are currently limited to sexual harassment claims only. The same is true of important legislation passed a few years prior that eliminated the Human Rights Law's four-employee employer size threshold for bringing a claim, but only for sexual harassment claims.

To effectively address and prevent workplace harassment, legal reforms cannot be focused exclusively on sexual harassment. They must cover all forms of harassment and discrimination. Workplace discrimination and harassment based on race, disability, color, religion, age, or national origin all undermine workers' equality, safety and dignity. Moreover, sexual harassment does not occur in a vacuum, but often occurs alongside or in combination with

other forms of harassment and discrimination. For example, a Black woman may experience harassment based on both her sex and race combined; she may be paid less than her male coworkers and also be the target of sexual comments and racial epithets. Indeed, EEOC charge data indicate that women of color—and Black women in particular—are disproportionately likely to experience sexual harassment at work, highlighting how race and sexual harassment can be intertwined. Out of the sexual harassment charges filed with the EEOC by women, 56 percent were filed by women of color; yet, women of color only make up 37 percent of women in the workforce.[8]

As a result, legislation that focuses exclusively on sexual harassment would have the odd and impractical result of providing a worker who experiences multiple, intersecting violations with only partial protection. The MeToo movement recognizes that in order to truly put an end to the workplace harassment that holds women back and enforces gender inequality, the movement—and our policy response—must be intersectional and address the multiple forms of workplace inequality women face that leave them more vulnerable to harassment.

Accordingly, it is crucial that these recently enacted protections against sexual harassment be amended (and future reforms be drafted) to extend to all forms of harassment and discrimination, as provided for in **S3817A/A7083A** and **A5976/S4109**.

B. STRENGTHEN PROTECTIONS AGAINST ABUSIVE USE OF NON-DISCLOSURE AGREEMENTS

We commend the legislature for passing legislation in 2018 to prohibit the use of non-disclosure agreements in settlement agreements that force harassment victims into silence, while still allowing a victim to request such a provision if it is their preference. We are concerned, however, that the informed consent provisions in the new law are inadequate to protect against an employer coercing an employee into "preferring" an NDA that they otherwise might not actually want. Given the inherent power imbalances between employer and employee—imbalances that are often magnified in the settlement context, especially when an individual may be dealing with trauma or is not represented by counsel—we are concerned that the legislation as passed may still permit employers to unduly push workers into silence.

Accordingly, we encourage the legislature to consider legislation to address the power dynamics in the settlement negotiation context, including:

- **Ensuring, as in A849-A/S5469, that workers who breach an NDA are not subject to liquidated damages.** Low-wage workers, in particular, often suffer significant economic hardship as a result of workplace violations and related retaliation, hardships that would be compounded by the harsh monetary penalties they would face for breaching an NDA provision.

- **Ensuring, as in A849-A/S5469, that an agreement to keep a settlement confidential should provide a reasonable economic or other benefit to the worker for that agreement, in addition to anything of value to which the worker is already entitled.**

- **Clarifying existing rights.** The law should specify as provided, for example, in **A869/S2037** that non-disclosure clauses in settlement agreements cannot explicitly or implicitly limit an individual's ability to provide testimony or evidence, file claims or make reports to any

federal or state enforcement agency, such as the EEOC, Department of Labor, or state counterpart. We also urge the legislature to clarify that a non-disclosure agreement cannot prevent an employee from providing testimony or evidence in state or federal litigation, including class or collective actions, against the employer. Legislation clarifying such rights should also require employers to expressly state in a settlement agreement that includes an NDA that the agreement does not prohibit, prevent, or otherwise restrict a worker from exercising these rights. Vermont, for example, now requires that settlements of sexual harassment claims clearly include an explanation that an NDA does not prohibit the worker from filing a complaint or participating in an investigation with state or federal agencies, such as the EEOC, or using collective action to address worker rights violations.[9]

We also encourage the legislature to consider clearly prohibiting employers from requiring employees, as a condition of employment, to sign nondisclosure or nondisparagement agreements that prevent employees from speaking about harassment and discrimination in the workplace. Abusive NDAs do not only exist in the settlement context. Too frequently, employers impose on new hires, as a condition of their employment, contractual provisions that prevent workers from publicly disclosing details of these worker rights violations. These contractual provisions can mislead workers as to their legal rights to report to civil rights or criminal law enforcement agencies and to speak with co-workers about employment conditions. They can also prohibit workers from publicly telling their story, which in turn makes it less likely that other victims of harassment will be emboldened to speak out and hold their employers accountable.

A1115, which requires employers to inform workers that NDAs in their employment contracts cannot prevent them from speaking with law enforcement, the EEOC, or a state or local human rights agency, is an important notice provision, but we urge the legislature to go further and directly prohibit employers from requiring an employee to enter into an NDA, as a condition of employment, that prevents them from speaking about harassment or discrimination. California, Maryland, Tennessee, Vermont, New Jersey, and Washington state[10] have all recently enacted legislation prohibiting employers from requiring workers to sign such non-disclosure or non-disparagement agreements as a condition of employment.

C. EXTEND THE STATUTE OF LIMITATIONS FOR UNLAWFUL EMPLOYMENT DISCRIMINATION TO PROMOTE WORKERS' ABILITY TO ACCESS JUSTICE.

Current New York law provides for one year from the most recent discriminatory act for filing an administrative complaint for unlawful employment discrimination with the New York Division of Human Rights. Short statutes of limitations like these can hamper the ability of individuals to bring harassment or discrimination complaints. Many victims do not come forward immediately, or even within months, to report, either due to the fear of retaliation and job loss, or as a result of the trauma they are experiencing. Additionally, many workers do not have the resources to easily find and consult with advocates or attorneys about their rights and legal options. For example, many people have felt empowered by the MeToo movement to seek information or assistance from the Times Up Legal Defense Fund, only to find that they have run out of time and no longer have legal options.

Accordingly, we encourage the legislature to extend the statute of limitations for filing an administrative complaint for unlawful employment discrimination from one year to at least three years as provided, for example, in **A1042/S2036**.

In 2018, New York City extended the statute of limitations for filing claims of gender-based harassment with the New York City Commission on Human Rights from one year to within three years after the alleged harassing conduct occurred.[11] And states across the country from Texas to Oregon are working on legislation this session to extend their statutes of limitations. In April, Maryland signed into law legislation extending their statute of limitations for filing an administrative claim to two years.[12]

D. ADDRESS HARMFUL INTERPRETATION OF THE "SEVERE OF PERVASIVE" STANDARD.

The standard that harassment must be "severe or pervasive" in order to establish an actionable hostile work environment claim has been repeatedly interpreted by courts in such an unduly restrictive fashion that the ability of individuals to pursue claims, hold perpetrators and employers liable, and obtain redress for the harm they have suffered has been severely undermined. Despite Congress' intent that Title VII provide a broad scope of protection from discrimination, some court decisions have interpreted the "severe or pervasive" language first articulated in the Supreme Court's 1986 decision in *Vinson v. Meritor Savings Bank* so narrowly as to recognize only the most egregious conduct as unlawful. While the "severe or pervasive" standard applies to all forms of harassment, the cases in the sexual harassment context provide especially shocking examples of the problematic manner in which this standard has too often been applied. For example, courts have dismissed claims involving sexual groping, repeated lewd and suggestive comments, and propositions because it was "just one or two" incidents of groping and thus wasn't sufficiently "severe," or because the conduct did not occur with enough frequency or regularity to be "pervasive."[13] In applying the "severe or pervasive" standard courts have too often looked at incidents of harassing conduct in isolation, instead of in totality, and have ignored critical context that increased the threatening nature of the harassment, such as the power dynamic between the harasser and the victim. Moreover, some lower court decisions have treated "severe or pervasive" as the only relevant factor in determining whether conduct violates Title VII, when the relevant inquiry is actually whether the harassing conduct altered the terms, conditions, or privileges of employment.

These interpretations create significant barriers to victims' ability to seek redress, and minimize and ignore the impact of harassment on individuals. As the state Supreme Court, Appellate Division, First Department pointed out in *Williams v. New York City Housing Authority,* this standard has "resulted in courts 'assigning a significantly lower importance to the right to work in an atmosphere free from discrimination' than other terms and conditions of work."[14] The harm from minimizing harassment not only extends to the court room, but trickles into the workplace. Because of the high "severe or pervasive" standard, victims may not step forward and make a complaint or seek help because they fear the harassment they are being subjected to would not be legally actionable. And, as the *Williams* court noted, setting the bar unduly high creates little incentive for an employer to create a workplace where there is no harassment.[15]

Accordingly, we encourage the New York legislature to pass legislation that would rectify the harm created by these interpretations of the "severe or pervasive" standard. New York City and California have passed legislation in recent years to move away from the unduly narrow interpretation of the standard for establishing a harassment claim.[16]

We urge the legislature to pass legislation that has the effect of ensuring that courts' analysis of workplace harassment focuses on the impact of the conduct on the individual's terms, conditions, or privileges of employment and recognizes that a wide range of circumstances may alter the terms, conditions, or privileges of employment, and that no single type, frequency, or duration of conduct is required to make a showing of severe or pervasive harassment. Moreover, the determination of whether conduct is actionable under New York employment discrimination law should be based on the record as a whole, taking into account the totality of the circumstances.

E. CLOSE LIABILITY LOOPHOLE CREATED BY *FARAGHER/ELLERTH* DEFENSE.

In *Burlington Industries, Inc. v. Ellerth* and *Faragher v. City of Boca Raton*,[17] the Supreme Court established an important principle under federal law: because a supervisor's ability to harass is a direct result of the authority given to the supervisor by the employer, the employer should be liable for the supervisor's actions unless the employer can show that it took steps to prevent harassment and to address harassment when it occurred, and that the employee failed unreasonably to take advantage of the opportunities provided by the employer to report and address the harassment. In theory, this rule encourages employers to put policies in place to prevent harassment and to respond promptly and effectively when harassment occurs.

Unfortunately, in practice, the *Faragher-Ellerth* defense has been largely ineffective in preventing harassment in the first instance and has become a box-checking exercise for many employers. Courts too often fail to conduct a searching analysis of employers' anti-harassment policies and practices and their efficacy, including whether employees understand how to make a harassment claim and whether they trust the employer's system for making a claim or didn't take advantage of the system because they fear retaliation or were discouraged from filing a claim. As a result, employers are able to evade liability by showing little more than they provide training or have a policy on the books, regardless of quality or efficacy.

Accordingly, to close this loophole, we encourage the legislature to consider legislation like **S3817A/A7083A,** that establishes that an employer's anti-harassment policies and procedures may not serve as a defense to liability, but may only be considered as a factor to mitigate damages. Moreover, such a factor should only be considered after courts and factfinders have evaluated the quality and efficacy of an employer's programs and policies – including its reporting system and prevention training programs – to ensure they meet the quality standards for employers of similar size and in similar industries.[18]

F. PERMIT PUNITIVE DAMAGES IN EMPLOYMENT DISCRIMINATION CASES.

While New York law provides for uncapped compensatory damages in employment discrimination cases, it does not permit punitive damages. Punitive damages, which punish employers who act with malice or reckless indifference to an employee's rights, provide an important incentive to employers to follow the law. Twenty-one states permit punitive damages for violations of the state's anti-discrimination protections, and in at least eight of those states, the punitive damages are uncapped.[19]

Accordingly, we encourage the legislature to amend New York employment discrimination law as provided, for example, in **S3817A/A7083A** to permit the recovery of uncapped punitive damages for claims brought before the State Division of Human Rights or in a civil action in court.

G. REQUIRE DISCLOSURE OR REPORTING OF DISCRIMINATION CLAIMS, CHARGES, AND LAWSUITS AND THEIR RESOLUTION.

Greater transparency around discrimination complaints or formal charges filed against an employer, and the resolution of those charges (including settlements), would help alleviate the secrecy around harassment, thereby empowering victims and encouraging employers to implement prevention efforts proactively.

Accordingly, the legislature should consider requiring the State Division of Human Rights to make publicly available the type and number of discrimination charges filed against a company, whether the charges were dismissed or resolved, and general information about the nature of the resolution (for instance, whether the charge was resolved through a monetary settlement). Such information could be made available on the agency's website, so that members of the public could conduct searches by company name. However, it is critical that any such effort balance transparency with steps to safeguard the identity of individuals filing charges.

Alternatively, the legislature could enact transparency initiatives requiring employers to affirmatively report to a state enforcement agency the number of discrimination complaints, lawsuits, and settlements filed against the company and the amounts paid, including through arbitration awards, which otherwise are typically secret. For example, in 2018, Maryland enacted legislation requiring employers with 50 or more employees to report to the Maryland Civil Rights Commission the number of sexual harassment settlements, the number of settlements against the same employee over the past 10 years, and the number of settlements with an NDA. The Commission was then instructed to aggregate and publish employers' responses.[20] New York City also enacted a similar law in 2018 requiring all city agencies to annually report on complaints of workplace sexual harassment to the Department of Citywide Administrative Services.[21] This information will be reported to the Mayor, the Council and Commission on Human Rights, which shall post it on its website. Information from agencies with 10 employees or less will be aggregated together.

The legislature could also enact a transparency initiative limited to state contractors that requires contractors, as a condition of submitting a bid or keeping an awarded contract, to fulfill certain conditions. First, the legislature could forbid state contractors from requiring employment-related claims to be subject to mandatory arbitration, or alternatively require state contractors to disclose information relating to their use of mandatory arbitration agreements. Second, contractors could be required to report regularly to the relevant agency the type and number of discrimination complaints or lawsuits filed against the company within a particular time period, and the nature of the resolution of claims or lawsuits. A similar model previously existed at the federal level in the form of Executive Order 13673 of 2014, commonly known as "Fair Pay and Safe Workplaces." The executive order and implementing regulations required federal contractors and subcontractors to disclose violations, within the three preceding years, of 14 enumerated federal labor and employment laws and executive orders, as well as their state equivalents.[22] Although the Trump Administration revoked the rule by executive order in March

2017,[23] Fair Pay and Safe Workplaces provides a valuable model for further consideration. Making even some portion of the reported information publicly available would provide job applicants and employees with valuable information about discrimination and harassment at a particular workplace. Such reporting also would encourage employers to implement practices to effectively address complaints and prevent sexual harassment.

H. Ensure reforms are accompanied by greater resource allocations to enforcement agencies.

Finally, substantive legal reform must be accompanied by additional funding for the State Division of Human Rights and other relevant agencies to increase their capacity to conduct outreach, education, employer training, investigations, and enforcement actions, and develop new resources for working people in all sectors including for low-wage workers. Without adequate resources to conduct these activities, the efficacy of many of the reforms being considered by the legislature may be undermined.

V. Conclusion

We appreciate your efforts to address workplace harassment and we thank you for your consideration of our recommendations. I am happy to serve as a resource as you continue to evaluate appropriate legislation and can be contacted at ajohnson@nwlc.org or 202-319-3041.

---

[1] 20 States By 2020 letter, https://www.ggenyc.org/20statesby2020/ (last visited May 21, 2019).
[2] EEOC, All Charges Alleging Harassment (Charges filed with EEOC) FY 2010 - FY 2018, https://www.eeoc.gov/eeoc/statistics/enforcement/all_harassment.cfm.
[3] EEOC, SELECT TASK FORCE ON THE STUDY OF HARASSMENT IN THE WORKPLACE, REPORT OF CO-CHAIRS CHAI R. FELDBLUM AND VICTORIA LIPNIC, Exec. Summary (June 2016), https://www.eeoc.gov/eeoc/task_force/harassment/report.cfm [EEOC TASK FORCE REPORT].
[4] EEOC, Retaliation-Based Charges (Charges filed with EEOC) FY 1997 - FY 2017, https://www.eeoc.gov/eeoc/statistics/enforcement/retaliation.cfm, and EEOC TASK FORCE REPORT, Part 2 C.
[5] Figures provided by the Time's Up Legal Defense Fund. For a summary of the work of the Time's Up Legal Defense Fund, see TIME'S UP LEGAL DEFENSE FUND, ANNUAL REPORT 2018 (Jan. 2019), https://nwlc.org/resources/times-up-legal-defense-fund-annual-report-2018/.
[6] *See, e.g.,* Diana Britton, Michael Thrasher, The Nature of the Beast, Apr 08, 2018, https://www.wealthmanagement.com/industry/nature-beast.
[7] NAT'L WOMEN'S LAW CTR., OUT OF THE SHADOWS: AN ANALYSIS OF SEXUAL HARASSMENT CHARGES FILED BY WORKING WOMEN (Aug. 2018), https://nwlc.org/resources/out-of-theshadows-an-analysis-ofsexual-harassment-charges-filed-by-working-women.
[8] *Id.* at 4.
[9] Vermont Act 183, H.707, Sec. 1(h), 2017-2018 Gen. Assemb., Reg. Sess. (Vt. 2018).
[10] S.B. 1300, 2018 Reg. Sess. (Cal. 2018); H.B. 1596, 2018 Gen. Assemb., Reg. Sess. (Md. 2018); H.B. 2613, 110th Gen. Assemb., Reg. Sess. (Tenn. 2018); H.707, 2017-2018 Gen. Assemb., Reg. Sess. (Vt. 2018); S.B. 5996, 65th Leg., 2018 Reg. Sess. (Wash. 2018); S.121, 2018-2019 Gen. Assemb., Reg. Sess. (Nj. 2019).
[11] New York, N.Y., Stop Sexual Harassment In Nyc Act, Int. No. 663-A (2018).
[12] HB 679, 2019 Gen. Assemb., Reg. Sess. (Md. 2019).
[13] *See, e.g., Black v. Zaring Homes, Inc*., 104 F.3d 822, 823–24 (6th Cir. 1997) (finding conduct insufficiently severe or pervasive where conduct over a four-month period involved repeated sexual jokes; one occasion of looking plaintiff up and down, smiling and stating, there's "Nothing I like more in the morning than sticky buns"; suggesting land area be named as "Titsville" or "Twin Peaks"; asking plaintiff, "Say, weren't you there [at a biker bar] Saturday night dancing on the tables?"; stating, "Just get the broad to sign it"; telling plaintiff she was "paid great money for a

woman"; laughing when plaintiff mentioned the name of Dr. Paul Busam, apparently pronounced as "bosom"); *Saxton v. American Tel. & Telegraph Co.*, 10 F.3d 526, 528, 534 (7th Cir. 1993) (finding insufficient harassment to constitute a hostile work environment where defendant supervisor placed his hand on plaintiff employees leg above the knee and rubbed her upper thigh, forced a kiss on plaintiff, and "lurched" at her in an attempt to grab her).
[14] *Williams v. N.Y.C. Hous. Auth.*, 872 N.Y.S.2d 27, 73 (App. Div. 2009) (citing Judith J. Johnson, *License to Harass Women: Requiring Hostile Environment Sexual Harassment to be "Severe or Pervasive" Discriminates among "Terms and Conditions" of Employment* (62 M.d. L. Rev. 85, 87 [2003])
[15] *Id.* at 76.
[16] S.B. 1300, Sec. 3, 2017-2018 Reg. Sess. (Cal. 2018); Int. No. 814-A (2016).
[17] *Burlington Indus., Inc. v. Ellerth*, 524 U.S. 742, 754-65 (1998); *Faragher v. City of Boca Raton*, 524 U.S. 775, 807 (1998).
[18] A Call for Legislative Action to Eliminate Workplace Harassment (Dec. 2018), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/10/Workplace-Harassment-Legislative-Principles.pdf.
[19] California, Hawai'i, Massachusetts, New Jersey, Ohio, Oregon, Vermont, and West Virginia.
[20] Disclosing Sexual Harassment In The Workplace Act Of 2018, S.B. 1010, Sec. 2, 2018 Gen. Assemb., Reg. Sess. (Md. 2018).
[21] New York, N.Y., Stop Sexual Harassment In NYC Act, Int. No.653-A (2018).
[22] Executive Order 13673, Fair Pay and Safe Workplaces, 79 Fed. Reg. 45309 (Aug. 5, 2014); Federal Acquisition Regulation; Fair Pay and Safe Workplaces, 81 Fed. Reg. 58562 (Aug. 25, 2016); Guidance for Executive Order 13673, Fair Pay and Safe Workplaces, 81 Fed. Reg. 58654 (Aug. 25, 2016).
[23] Executive Order 13782, 82 Fed. Reg. 15607 (Mar. 30, 2017).

Testimony

Good morning. Thank you for the opportunity to testify at this morning's hearing.

I am Miriam Clark, the president of National Employment Lawyers Association, New York affiliate.

I have been representing employees, including victims of sexual and other forms of harassment, for more than thirty years.

At this hearing, and at the ground breaking hearing in February, we heard an outcry of pain and outrage about sexual harassment in the workplace. As a lawyer who has been representing survivors of sexual and other forms of harassment for more than thirty years I am here to tell you that outrage without legislative change is meaningless. New York law is regressive and throws up barrier after barrier to employees seeking justice in the courts.

At the outset, I want to address a concern that I know many of you may have about strengthening the laws against unlawful discrimination and harassment. You may have heard that strengthening these laws will cause economic hardship to New York business, especially small businesses.

In fact, study after study has shown that unlawful harassment and discrimination itself are bad for businesses.

Employees who are harassed and discriminated against suffer physical and psychological illness, which lowers their productivity. Studies show that women

of color report the highest level of discrimination in the workplace and are most likely to suffer symptoms of post traumatic distress disorder as a result of such experiences. See e.g. Okechukwu CA1, Souza K, Davis KD, de Castro AB. 2014. “Discrimination, harassment, abuse, and bullying in the workplace: contribution of workplace injustice to occupational health disparities” *Am J Ind Med*. 2014 (May);57(5):573-86. doi: 10.1002/ajim.22221. Epub 2013 Jun 27.

Employees who suffer from unlawful discrimination and harassment quit. A workplace rife with unlawful harassment will suffer turnover, which experts estimate cost employers anywhere from 20 to 213 percent of salary. Shaw, Elyse, Hegewisch, Arlene, Hess, Cynthia. “Sexual Harassment and Assault at Work: Understanding the Costs”. 2018. Institute for Women’s Policy Research, October 15, 2018. https://iwpr.org/publications/sexual-harassment-work-cost/ Overall, it is estimated that each person on a team affected by sexual harassment is less productive, with an average cost through lost productivity of $22,500 per person. Id.

Common sense and lived experience tell us that this must be the case. My clients who suffer from sexual and other forms of harassment, dread going to work every day. They suffer from physical and psychological symptoms, are exhausted by the emotional and physical energy involved in trying to get away from their harassing supervisors or co-workers, and by fear of retaliation if they complain. Those with

the ability to leave their jobs almost always do so. Who stays? The harasser, free to make the life of the next employee miserable.

Before I explain the legislative change that is needed, we should discuss the specific weaknesses in New York law.

New York's anti-discrimination law is more than 75 years old. NY courts have chosen to interpret it to align with federal law, which has gotten significantly less employee-friendly over the years, and is likely to become even worse as Trump-appointed federal judges pack the courts.

Moreover, due to a very frequently used procedural mechanism called "summary judgment", judges dismiss many employment discrimination cases before they ever get to a jury. Studies in the New York federal courts have found that on average, less than one third of employment discrimination cases survive such motions. The cases that are most likely to survive are "pure" sexual harassment cases -- but even they get to juries only half the time. Berger, Vivian, Finkelstein, Michael, Cheung, Kenneth. 2005. "Summary Judgment Benchmarks for Settling Employment Discrimination Lawsuits." *Hofstra Labor and Employment Law Journal* 23:1.

Why is it so hard for New Yorkers who suffer from unlawful harassment and discrimination to get their cases to trial, let alone win their cases? The answer

is that New York law overwhelming protects employers from liability instead of protecting employees from discrimination.

1. Discriminatory harassment is only illegal if a court believes that it was "severe or pervasive". I gave some graphic examples of outrageous conduct that judges found not to be "severe or pervasive" in my February testimony. Here are some newer ones, not in the purely "sexual harassment" context:

In a 2018 case involving a black woman, a court held that being called a "bitch" and "black bitch" numerous times, along with comments such as "this bitch thinks she's the shit" and "you black people think you are the shit" did not constitute "severe or pervasive" harassment. Fletcher v. ABM Building, 14 Civ. 4712 (S.D.N.Y. March 28, 2018)

Also last year, the appellate court affirmed a lower court who held that the following conduct suffered by an African-American public school teacher, was not "severe or pervasive".

(1) Plaintiff's colleague forwarded an extremely derogatory email comparing a minority teenager as a "downwardly evolved" human -- "homo slackass-erectus." The caption said, "This species receives benefits and full government care. Unfortunately most are highly fertile."

(2) Another teacher referred to African Americans as "Alabama porch monkey[s]".

(3) Another teacher complained that she did not want "another Hernandez" in her class,

(4) The same teacher told Plaintiff in front of his class that it was her right as an American to use the N-word;

(5) A baseball coach told an African-American student that "he runs as fast as a runaway slave"

Berrie v. Bd. of Educ of the Port-Chester Rye Union Free School District. 2017 U.S. Dist. LEXIS 83623 (S.D.N.Y. May 31, 2017). The Second Circuit affirmed, 750 Fed. Appx. 41 (2d Cir. 2018), holding that eleven incidents over five years is not "severe or pervasive" enough to create an environment that would reasonably be perceived, and is perceived, as hostile or abusive, citing, inter alia Stembridge v. City of New York, 88 F. Supp. 2d 276, 286 (S.D.N.Y. 2000) (seven racially insensitive comments over three years, including one instance of calling the plaintiff the "n-word," were not pervasive).

2. New York employers also escape liability because they are often held to be not responsible for hostile work environments created by their low-level and mid-level supervisors. The only exception is in the rare situation where the employee can prove that the employer encouraged, condoned, or expressly or impliedly approved the supervisor's conduct. See Human Rights ex rel. Greene v. St. Elizabeth's Hosp., 66 N.Y.2d 684, 687, 487 N.E.2d 268, 496 N.Y.S.2d 411 (1985). Most New

York state courts follow the federal standard, which gets the employer completely off the hook if the employee failed to promptly use a "reasonable avenue of complaint" provided by the employer. See e.g. Quinn v. Green Tree Credit Corp., 159 F.3d 759, 1998 U.S. App. LEXIS 28108, 78 Fair Empl. Prac. Cas. (BNA) 371, 74 Empl. Prac. Dec. (CCH) P45,617 (2d. Cir 1998); McNeil v. N.Y. State Office of Substance Alcoholism & Substance Abuse Servs., 2017 U.S. Dist. LEXIS 34930 (E.D.N.Y., March 9, 2017).

However, all available research shows that most employees who suffer from unlawful hostile work environments do not complain -- usually because they have a justifiable fear of retaliation. Feldblum, Chai R. and Lipnic, Victoria. 2016. "Equal Employment Opportunity Commission, Select Task Force on the Study of Harassment in the Workplace, Report of Co-Chairs" June 2016 at 16. https://www.eeoc.gov/eeoc/task_force/harassment/report.cfm

3. In some ways, New York state law is worse than federal law. It does not provide for punitive damages, which means that awards, especially to low wage workers, tend to be low and absorbable by the employer as a cost of doing business. This is because damages in employment discrimination cases, including sexual harassment cases, are measured by the worker's economic loss and her emotional distress. If an employee can't afford psychotherapy, and she is a low wage worker forced to quit because of sexual harassment, the damages she

receives even if she wins her case, may be minimal to the employer. The employer is incentivized to continue to employ the harasser and to allow the harassment to continue, viewing the amount paid to the employee as a cost of doing business.

5. Under New York law, an employee who wins a case can have the employer pay legal fees ONLY if the case was based on sex discrimination. Also, small employers are allowed to commit all forms of discrimination except sex discrimination and employers are only responsible for the acts of independent contractors if the unlawful conduct was based on sex discrimination. As we will describe later, these anomalies allow many forms of discrimination, including discrimination against women of color, to go completely unchecked.

I want to emphasize again that outrage without legislation is meaningless. And well-intentioned legislation that focuses only on training, or policy language, or on a particular form of discrimination, avoids the fundamental changes needed in the substantive law itself.

S 3817A/A7083A introduced by Senator Biaggi, Assembly Member Simotas, numerous co-sponsors and supported by more than 30 organizations including Make the Road New York, Legal Momentum, the Chinese Staff and Workers Association, Latino Justice, the Center for Participatory Democracy and A Better Balance, effectuates these desperately needed changes.

The bill:

-- eliminates the “severe or pervasive” standard. Under the bill, a hostile work environment would be unlawful unless it consists merely of a “petty slight or trivial inconvenience” -- a much lower standard based on NYC law.

-- holds employers liable for the discriminatory and harassing acts of their supervisors and for the conduct of independent contractors.

-- allows employees who prove they have been unlawfully discriminated against or harassed can obtain punitive damages and have their attorney fees paid by the employer.

--protects employees of small employers and independent contractors

The Me Too movement and even the press coverage around these hearings may have led some of you to believe that all we need to do to right these injustices is to strengthen laws against sexual harassment. Given the press coverage, this assumption may be understandable, it’s also dead wrong, as my colleague Laurie Morrison will explain.

<u>SENATE HEARING TESTIMONY</u>

Hello, I am Laurie Morrison, and I have been representing victims of employment discrimination, harassment and retaliation for almost 2 decades. I am also a member of the National Employment Lawyers Association (NELA), New York affiliate.

As Miriam described, the bill proposed by Senator Biaggi and Assembly Member Simotas, S3817A/A7083A seeks to eliminate the severe or pervasive requirement for proving discriminatory harassment. This bill provides important protections and I want to emphasize today how important it is that the bill be passed in its current format and not be modified to address only sexual harassment.

If that were to happen, disastrous unintended consequences would follow. For example:

- If a Woman is smacked on the buttocks in the workplace, then the law will protect her.
- However, if there is a noose hung in the workplace – then the victims need to prove severe or pervasive before the law will help them.
- If a swastika is painted in the workplace – then, again, victims need to prove severe or pervasive before the law will help them.

And, the issue becomes increasingly more problematic when discrimination & harassment occurs because of gender/sex AND other characteristics.

- For example, where a Black Woman is called a "Black B" in the workplace -- or is called "B" When White Women is Not Called "B", this indicates that not only gender, but also race discrimination are at play <u>*simultaneously*</u>.

That is what I am going to focus on here today – <u>*intersectionality*</u>. When victims are targeted in the workplace because of more than one characteristic – be it gender & race; gender & disability, etc.

<u>I – INTERSECTIONALITY RESEARCH</u>

<u>Intersectionality Scholars</u> - used a representative sample of judicial opinions over 35 years of federal employment discrimination litigation. The results showed that nonwhite women are less likely to win their cases than any other demographic group.

Additionally, plaintiffs who make intersectional claims, alleging that they were discriminated against based on more than one ascriptive characteristic, are <u>*only half as likely to win*</u> their cases as are other plaintiffs.

These results suggest that antidiscrimination lawsuits provide the *least* protection for those who already suffer multiple social disadvantages, thus limiting the capacity of civil rights law to produce social change.

***Multiple Disadvantages: An Empirical Test of Intersectionality Theory in EEO Litigation*, 45 Law & Soc'y Rev, 991 (2011).**

Other Intersectionality Research found that:

Found a modern manifestation of bias that alienates women and people of color from work life. Theories of double jeopardy and intersectionality suggest that women of color may be most at risk for mistreatment.

***Selective Incivility as Modern Discrimination in Organizations: Evidence and Impact*, Journal of Management, Vol. 39 No. 6, September 2013, 1579-1605**.

Similarly, other Research

Examined the different types of sexual harassment experienced by Black and White women in the military.

They found that Black enlistees reported more sexual coercion than White enlistees; Black women reported more psychological distress following gender harassment than White women, and enlisted women reported more distress following gender harassment, unwanted sexual attention, and sexual coercion than officers.

***Buchanan, N. T., Settles, I. H., & Woods, K. C. (2008). Comparing sexual harassment subtypes among black and white women by military rank: Double jeopardy, the jezebel, and the cult of true womanhood*. Psychology of Women Quarterly, *32*, 347-361. doi: http:// 10.1111/j.1471-6402.2008.00450.x**

I also want to thank Intersectionality Scholar, Leah Warner, for Compiling The Research and for her invaluable contributions to this testimony.

Studies have repeatedly shown that harassment has so much to do with a power dynamic. Victims are those who are perceived as weaker, as having less ability – physically, socioeconomically, politically, etc. -- to avoid or stop the harassment. What occurs is that – yes, Woman are shown to be more often sexually harassed in the Workplace than Men. However, Racial Minorities Are Also Deeply Vulnerable to Sexually Harassment because we are still dealing with that same power dynamic. Also add, Disabled Women, who may be more vulnerable than those who are not disabled. Younger Women or Older Women are also vulnerable, etc..

If We Overlook These Fundamental Aspects of Harassment – Then We Help The Harassers Achieve Their Goal -- Because We Reduce Protection for The Other Characteristics (such as race, ethnicity, disability) That Harassers Prey On To Target Victims.

And, this Negatively Effects ALL OF US – not solely racial/ethnic minorities.

That Also Means That Our Law Is Telling Each And Every One Of Us: Your Sex/Gender Matters And Is Protected – But, Your Race/Ethnicity Is Not As Protected. With All The Divisions Occurring in Our Nation & In Our World Today – Do We Really Want Laws That Provoke Further Division In Ourselves? Do we want Laws That Force Us To Take Human Beings And Divide And Devalue Portions Of Who We Are???

It is also Very Important To Note that the vast majority of employers do NOT have an interest in creating racial, ethnic and/or discriminatory tensions within workplace. A law that requires employers to treat workers differently based on gender, racial, ethnic and/or other grounds, creates and perpetuates tension in the workplace and division between workers.

II - Arbitrarily Splitting A Whole Person Into Parts

a) I am a Black Woman. That is obvious by looking at me. You see my mocha colored skin. And, you see my traditionally considered "Female" features. Seeing Me Before You, My Color and My Gender are as Plain & Clear as Day.

    a. Looking at me – do you split my characteristics into only being a Woman? Suddenly you cannot see my color at all? Am I suddenly a translucent Woman – devoid of any color? Of course not.

    b. Looking at me – do you remove the woman part and now I am only a skin color – devoid of a gender?

    c. Sometimes people say that they are color-blind – likely meaning that they do not attribute any animosity or negativity to race. That does not mean that they literally cannot see the color of someone's skin. Of course we can.

    d. Fracturing me or anyone else into one trait – at the exclusion of obvious other traits – causes us to be willfully blind to all of who I am. And, all of what we all are.

    e. As importantly, it makes us invisible – as if who we are, the totality of who we are, *is not worth seeing*.

IV- Decision-Makers, Judiciary, etc. – Not Have Benefit of Seeing Victim In Front of Them, so decisions made in relative blindness

As Miriam described, many discrimination cases are dismissed by judges as a result of summary judgment motions. Lawmakers, Law Enforcers, Courts, Etc. Do Not Have The Benefit Of Seeing The Victims Of Harassment and discrimination In Front Of Them When They Determine If Harassment is Sufficiently Severe or Pervasive.

a) Most Pertinently – this meanst that Most Employment harassment and discrimination Cases are Decided on paper -- *without decision-makers/Courts/Jury ever seeing the victims or ever hearing the victims tell their stories face-to-face*.

b) The result is that Decisions are Made With Eyes Closed To The Apparent & Valid Physical Characteristic that We Can All See When We Looking At the Person face-to-face.

If New York State passes laws that grant stronger protections against sexual but not against other forms of discriminatory harassment, the result is State Encouraged and State Perpetuated Devaluation – Minimization – and Segregation. Segregation of Our Race from Our Gender. Splintering Who We Are And The Abuse That We Are Being Subjected To.

V - Law Is Supposed To Protect ALL EMPLOYEES From Discrimination, Harassment and Retaliation.

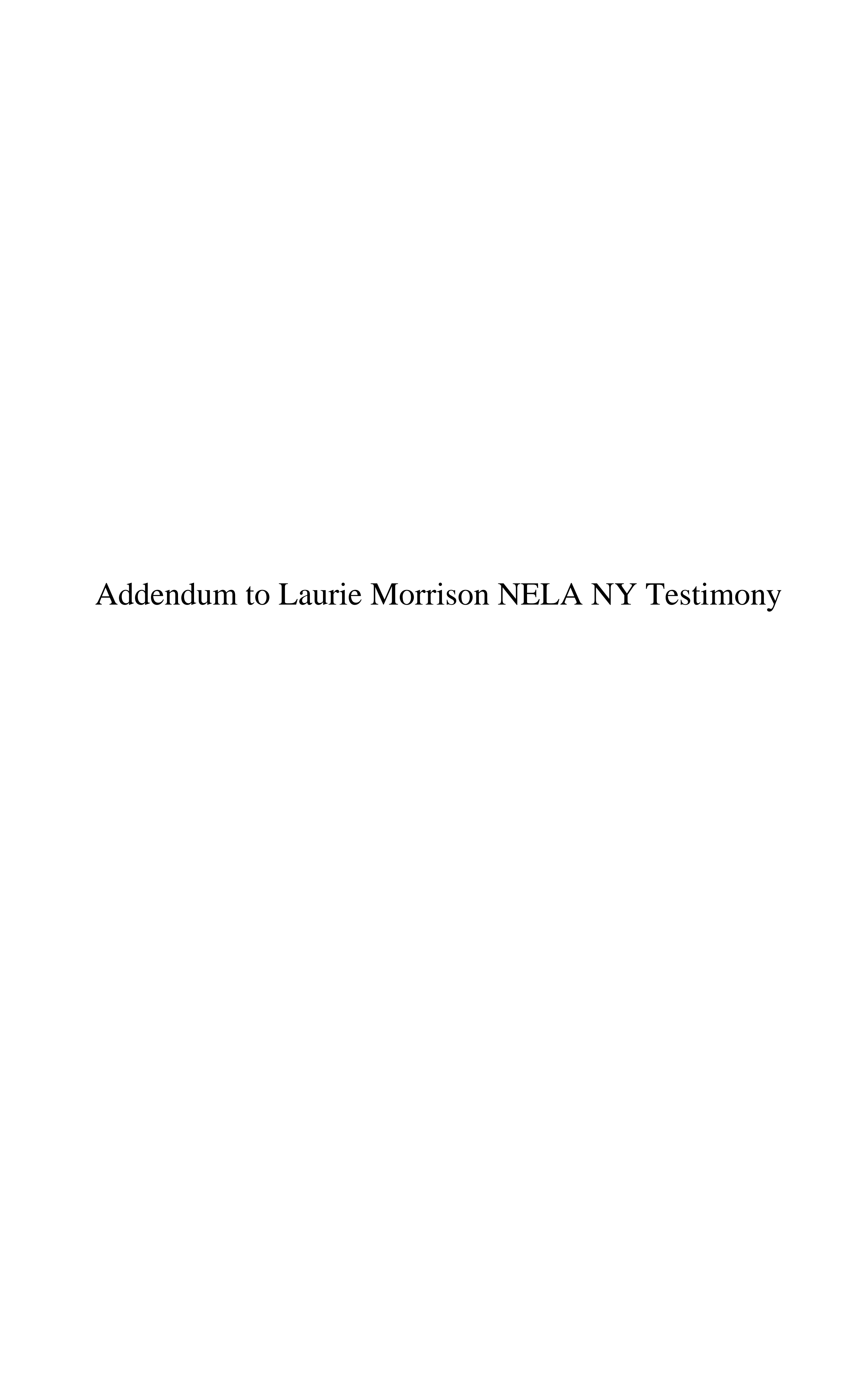
a) However, the Law Cannot Possibly Do That, If The Law Itself Discriminates.

b) The Law Informs The Workplace. If employers are instructed that hostile work environments not based only on sex are perfectly legal so long as the abuse is not "severe or pervasive", that tells employers and employees alike That Black Women Matter Less, That Hispanic Women Matter Less, That Jewish People Matter Less, That Homosexual People Matter Less, The List Goes On And On.

c) As Frightening – A law that focuses only on sexual harassment Will Tell Harassers, Loud And Clear: Stay Away From White Women, But Everyone Else Is Relatively Free Game.

CONCLUSION

Legislation must be passed now to eliminate barriers to justice for all victims of illegal harassment and discrimination. Such legislation must also eliminate the law's current preference for sex over other forms of discrimination and make clear that all forms of harassment and discrimination based on protected characteristics are equally unacceptable in New York workplaces.


Addendum to Laurie Morrison NELA NY Testimony

Oxford Handbooks Online

Multiple Groups, Multiple Identities, and Intersectionality

Isis Settles and Nicole T. Buchanan

The Oxford Handbook of Multicultural Identity
Edited by Verónica Benet-Martínez and Ying-yi Hong

Print Publication Date: Jul 2014
Online Publication Date: Jan 2014
Subject: Psychology, Personality and Social Psychology
DOI: 10.1093/oxfordhb/9780199796694.013.017

[–] Abstract and Keywords

This chapter reviews the construct of intersectionality in relation to multiple social-group memberships and multiple social identities. Intersectionality theory stresses the importance of considering an individual's combination of group memberships and identities to more thoroughly understand the individual's unique social experiences and worldview. We apply intersectionality to multiple group memberships, noting how membership in multiple marginalized groups places individuals at risk for negative experiences and well-being (multiple jeopardy), whereas membership in multiple privileged groups increases the likelihood of positive experiences (multiple advantage). Next, we discuss intersectionality theory in relation to multiple social identities as they are associated with psychological well-being, processes of identity conflict, and models of identity integration. We conclude with questions and issues informed by intersectionality theory related to multiculturalism, multiple group memberships, and multiple identities.

Keywords: intersectionality theory, social identities, social groups, identity integration, psychological well-being, race, gender, multiple jeopardy, multiple advantage, identity conflict

Introduction

In this chapter we discuss intersectionality theory, which emphasizes how combinations of social-group memberships and social-group identifications create unique social positions for individuals, which influence their perceptions of the world, experiences, and outcomes (Cole, 2009; Crenshaw, 1989/1993). We begin by describing the processes of categorization and stereotyping related to social-group memberships. We then describe the history and tenets of intersectionality, and how intersectionality can be applied to the processes of categorization and stereotyping. Specifically, we discuss how individuals are categorized and stereotyped based on their intersectional positions, as well as how individuals self-identify with intersected categories. Next we discuss how intersectionality theory is relevant to group memberships, particularly for devalued social-group members. We further describe processes involved in social-group identifications in relation to psychological well-being and the integration and organization of multiple identities. We end by raising questions that an intersectionality lens brings to thinking about multiple group memberships and multiple group identifications. Intersectionality theory has a great deal to offer the literature on multiculturalism and multiple identities because of its emphasis on the social context and historical factors that influence how cultures, racial groups, and individuals with various identities are perceived and situated in society.

Social-Group Memberships and Identifications

Individuals belong to a number of different social groups simultaneously, based on a variety of characteristics they posses. For example, a woman may be Asian-American, working-class, (p. 161) and heterosexual. Individuals

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

categorize themselves and others based on salient characteristics (Fiske & Neuberg, 1990), such as gender and race, forming social groups around these shared factors. The process of categorization is a means of reducing a large amount of information into a more manageable size. Individuals can then apply their "knowledge" about the social category (e.g., Asian-Americans or Asian-American women) when they encounter new people who fit into the group (Brewer, 1988; Fiske & Neuberg, 1990).

However, an individual's knowledge about social category members is not necessarily neutral or accurate. Rather, group memberships (and knowledge about individuals in those groups) are typically based on historical experiences and the social context (Williams, Lavizzo-Mourey, & Warren, 1994). Thus, social groups may be stereotyped in ways that reflect the current social system that provides status to some groups and marginalizes others; further, stereotypes often act to maintain the relative social status of groups (Williams et al., 1994). For example, Diekman and Eagly (2000) asked participants to provide stereotypes of women from past, present, and future generations, and they found that stereotypes of women of the past were less masculine than stereotypes of women of the present, and these changes corresponded with perceived changes in women's social roles. Because stereotypes are believed to be valid by those who hold them (Haslam, Oakes, Reynolds, & Turner, 1999), they also impact how individuals in social groups are treated (Fiske & Neuberg, 1990). Thus, because women are stereotyped as nice but not competent (Fiske, Cuddy, Glick, & Xu, 2002; White & Gardner, 2009), women may be treated as though they are incompetent and unable to hold positions requiring skill and ability, with potential consequences for their academic, occupational, and social experiences.

Although group memberships vary in their salience, some tend to consistently form the basis of categorization over other possible categorizations. Race/ethnicity, gender, and age are some such social categories, and they have been described as primary, natural, or superordinate (Brewer, 1988; Brewer & Lui, 1989; Heilman, 1995). Part of the primacy of these social categories is due to their visibility and stability. Categories like race, gender, and age are usually visible such that one's membership in a particular racial/ethnic, gender, or age group can be ascribed to the individual based on the perception of others, regardless of how the individual would choose to classify herself or himself. Additionally, for race and gender, few individuals move between categories within the group (e.g. from one racial group to another). This is in contrast to social categories like social class and sexual orientation, which are typically less visible and may be somewhat fluid over the life course.

We distinguish group memberships and categorizations from group identification. Identification with a social group occurs when individuals see themselves in terms of a group they belong to and accept the group membership as a part of their self-concept and self-definition (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Hogg, 2006; Thoits, 1995). Through identification with groups, individuals derive a sense of meaning (Demerath, 2006; Thoits, 1995) and guidelines for understanding the world and interacting with others (Hogg & Abrams, 1990). Identities provide perspective, or a particular way in which to view the world (Sacharin, Lee, & Gonzalez, 2009). Once identities are formed, a prototype is developed. Prototypes are cognitive representations of an ideal group member (Hogg, 2006). Often, identified individuals will engage in self-stereotyping, which involves taking on characteristics of the group prototype (Hogg, 2006).

In sum, identification reflects the extent to which individuals place importance on their group memberships. In contrast, others may categorize individuals into different groups than individuals would categorize themselves. For example, a Middle Eastern-American man may categorize himself as White (rather than Middle Eastern), whereas others categorize him as an ethnic minority and treat him according to the stereotypes of Middle Easterners. Additionally, he may not place importance on being Middle Eastern in how he defines himself. Thus, he would describe and categorize himself as White, and he would not identify with being Middle Eastern although others view him this way.

We feel that the distinction between group memberships and group identifications is important, although both are relevant to intersectionality. Whereas group memberships often influence how individuals are treated by others (through the processes of categorization and stereotyping), group identification reflects one's sense of self (through the process of self-categorization). As a result, for individuals who belong to marginalized groups, group memberships and the occupation of particular intersectional positions may lead to stress and mistreatment. Alternatively, occupation in advantaged groups may provide individuals with (p. 162) resources and privileges. In both cases, however, the treatment of individuals is somewhat independent of their self-identification (although we note that individuals engage in various processes and behaviors to create particular images and representations

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

of themselves). However, individuals have greater control over their identifications—the groups by which they choose to define themselves. Thus, even for marginalized group members, identities may provide psychological benefits and protections for individuals.

Intersectionality Theory

Intersectionality theory posits that it is important to consider the multiple social groups individuals occupy because the combination of groups creates a unique space with a unique social meaning (Cole, 2009; Crenshaw, 1989/1993). That is, the meaning of one social group (e.g., gender) depends on the other groups the individual belongs to (e.g., race, social class; Shields, 2008). For example, being a Black middle-class woman is different from being a White middle-class woman. Yet research on middle-class women might focus primarily on the experiences of those who are White. An intersectional perspective would notice that such research did not reflect the experiences of all middle-class women, and it would try to examine areas of similarity and difference for other types of middle-class women. Thus, intersectionality pays attention to the fact that the combination of social-group memberships changes individuals' life experiences (Shields, 2008).

The ideas inherent in intersectionality theory gained prominence in the 1970s when members of the U.S. Black feminist movement expressed that they experienced multiple forms of oppression simultaneously and thus were unable to separate oppression based on single identities (Combahee River Collective, 1977/1995). The term *intersectionality* was coined by Crenshaw (1989/1993); she highlighted the fact that the oppression of Black women was not equivalent to oppression experienced by White women or Black men. Despite the initial and continued focus on how intersecting social-group memberships may lead to unique forms of oppression and marginalization, many psychologists find it useful to consider how intersecting social positions can also lead to privilege and opportunity (Cole, 2009; Shields, 2008). For example, White men, particularly those who are heterosexual and middle-class, occupy a privileged position on the basis of their intersecting group memberships. In other cases, one might be marginalized on the basis of one group membership but privileged on the basis of another membership that together create one's intersectional social position (Cole, 2009; Shields, 2008). This would be the case for White women who are privileged because of their race but oppressed because of their gender.

There are a number of strengths offered by intersectionality theory. First, it is consistent with individuals' lived experiences. All individuals simultaneously belong to a number of social groups and hold multiple social identities. Yet, most psychological research has examined single categories of group membership or identity. By doing so, such research may oversimplify relationships or tend to focus on the experiences of only the most privileged subgroup (Cole, 2009). Second, an intersectional approach, by asking who is included and who is omitted in a category, can also work toward deconstructing who is perceived to be the normative subgroup within a broader social category (Cole, 2009; Jordan-Zachery, 2007). For example, an intersectional lens would allow us to notice that most research on women is really research on White women. Third, we can use intersectionality to understand similarities and differences between groups (e.g., men and women) and within groups (e.g., different types of women; Cole, 2009; Crenshaw, 1991; Jordan-Zachery, 2007). By focusing on both differences and similarities, an intersectional perspective may limit individuals' tendency to essentialize differences (Crenshaw, 1991; Jordan-Zachery, 2007). A focus on similarities among groups can also lead group members to find areas of overlapping concerns, which can be a useful tool for mobilizing multiple groups around political causes (Cole, 2009).

Researchers have suggested that there are many approaches to using intersectionality theory. First, it can be used as a theoretical perspective that guides the types of questions researchers ask (Shields, 2008). For example, using an intersectional lens, Hurtado and Sinha (2008) asked how self-identified feminist Latino men defined what it means to be a man. Because of their use of intersectionality theory, Hurtado and Sinha (2008) noted that masculinity is defined as being White, rich, and heterosexual; as a result, Latino men do not have full access to the privileges of manhood. Among their results, the researchers found that Latino feminist men frequently discussed gender and gender-related issues in terms of multiple social-group identifications (i.e., race, ethnicity, social class, sexuality) and many participants rejected the notion of manhood (p. 163) as requiring the objectification of women (Hurtado & Sinha, 2008).

Second, intersectionality can be used analytically, to describe underlying relationships and processes (Jordan-

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Zachery, 2007). Analytically, an intersectional perspective does not need to test for and find differences between groups (e.g., White women versus Black women). Rather, the goal is to explain the process by which membership in one or more social groups changes, shapes, and defines membership in another social group (Shields, 2008) and, by extension, how outcomes differ based upon these intersecting groups. Qualitative research by Settles, Pratt-Hyatt, and Buchanan (2008) found that some aspects of womanhood differed for Black and White women. For example, struggles about merging work and family roles emerged for White women but not Black women, perhaps because Black women have historically always combined these roles. In a quantitative study, Buchanan, Settles, and Woods (2008) found that White women in the U.S. military received more sexual harassment that expressed that they were unwelcome, whereas Black women received more sexualized forms of sexual harassment, such as unwanted touching. These differences were theorized to exist because White women are expected to hold social roles as mother and caretaker, rather than soldier, and thus are violating stereotyped norms; harassment that emphasized White women's unsuitability in the military may have served to remind them of their "place." In contrast, sexualized stereotypes of Black women as promiscuous may have made sexual-advance types of harassment seem more permissible when directed toward women in that group.

Third, intersectionality can be used as a political tool (Jordan-Zachery, 2007). Politically, intersectionality can highlight areas of inequality based on an individual's intersectional position and how these inequalities relate to the larger political system (Jordan-Zachery, 2007). For example, Crenshaw (1991) wrote about the invisibility of Black women in the legal system because they could file lawsuits based on racial discrimination in the workplace or gender discrimination in the workplace, but not both forms of oppression, despite feeling discriminated against on the basis of this intersected position. An intersectional approach can also shed light on the goals and needs of subgroups within a political movement or political group (Cole, 2008). Cole (2008) highlights from her research that activists often try to forge alliances based on "shared interests rather than shared identities" (p. 447).

Intersectionality and Social-Identity Processes

The processes that apply to individual social categories, group memberships, and social identities may also apply to intersecting categories, memberships, and identities. In fact, Goff, Thomas, and Jackson (2008) suggested that there is no theoretical reason to expect race, gender, or age to be more basic or primary categories than a combination of these group memberships. Accordingly, the stereotypes of intersectional positions sometimes differ from those of the categories that comprise the intersection. For example, "women" are stereotyped as being nurturing, kind, helpful and concerned with others (Heilman, 1995, 2001). However, research that examines stereotypes of women of different racial groups finds that the stereotype of a woman is actually the stereotype of a White woman. In contrast, African-American women are described as loud, talkative, and antagonistic; Asian-American women are described as quiet, shy, well-mannered, and achievement oriented; and Mexican women are described as loud, promiscuous, and family oriented (Niemann, Jennings, Rozelle, Baxter, & Sullivan, 1994). Niemann et al. (1994) also found some commonalities across race-gender groups, such as all females being described as intelligent and pleasant. Nevertheless, many of the stereotypes differed for women of different racial/ethnic groups, suggesting that participants in the study considered the intersection of race and gender when recalling stereotypes.

Other research on group evaluations supports the idea that individuals may categorize others based on intersecting group memberships, like race and gender. For example, in a scenario study, African-American female professors were rated lower on legitimacy and competence than African-American male professors, and Caucasian and Asian professors of both genders (Bavishi, Madera, & Hebl, 2010). In a study of teaching evaluations of actual college professors, Reid (2010) found that racial-minority faculty members were rated more negatively than White faculty, and that Black male instructors were rated especially poorly. Thus, participants are rating hypothetical and real professors based on both their race and gender, although the reason for the different findings between these studies is unclear.

Categorizing on the basis of intersections does not apply only to combinations of race and gender. Again referring to the earlier stereotype of a white woman, we note that this is largely the stereotype (p. 164) of a middle-class (White) woman. Compared to a hypothetical middle-class woman, Lott and Saxon (2002) found that a hypothetical working-class woman was described more as crude, irresponsible, and meek. These results are similar to those of an earlier study by Landrine (1985); she found that middle-class women were rated as more intelligent, ambitious,

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

and warm, whereas lower-class women were described more as dirty, hostile, impulsive, and irresponsible. Additionally, the stereotype of a "woman" does not apply to lesbian women who are rated more as masculine than heterosexual women (Kite & Deaux, 1987). Thus, individuals may be categorized by others on the basis of their intersecting identities, stereotyped according to these intersections, and treated correspondingly.

There is also some evidence that individuals—at least some individuals in some contexts—see themselves in terms of intersecting identities. Research in this area is limited because quantitative research typically asks people to report on single identities (e.g., race, sexual orientation) rather than intersections (e.g., being an Asian-American lesbian). However, research by Settles (2006) found that Black women rated their "Black woman" identity as more important than either their "Black" or "woman" identities. Additionally, Bowleg's (2008) qualitative research on Black lesbian women found that they often thought of themselves in terms of intersecting identities such as Black female lesbian or Black lesbian.

Intersectionality and Multiple Group Memberships

According to intersectionality theory, membership in various social groups (e.g., gender, race, class, sexual orientation) are interconnected and their meaning is fully understood only when all identities are considered in relationship to one another (Cole, 2009). In this section, we discuss how memberships in multiple marginalized or privileged groups lead individuals to have more negative or positive experiences, respectively. We also describe intersectional invisibility, a theory detailing how multiple marginalized group memberships can sometimes render individuals to be invisible and overlooked (Purdie-Vaughns & Eibach, 2008).

Double-jeopardy theory (Beal, 1970; D. K. King, 1988) applies an intersectional framework to propose that individuals in two disadvantaged or marginalized groups will be at increased risk for negative experiences, such as poverty, victimization, and mental and physical health disparities. Jeffries and Ransford's (1980) *multiple-jeopardy-advantage hypothesis* extended the double-jeopardy model to specifically address belonging to three or more groups and to account for the fact that individuals can belong to multiple marginalized or multiple privileged groups, which affords individuals in those groups differential power, status, and resources. Both of these hypotheses (double jeopardy and multiple jeopardy-advantage) posit that each identity (gender, race, social class, sexual orientation) represents a status dimension and that individuals' experiences are determined by their unique placement on these intersecting dimensions. As such, examining a single status dimension will not adequately account for one's life circumstances and outcomes. Thus, these theories reflect intersectionality theory in at least two ways: (1) they stress that one must consider individuals' multiple group memberships, because intersecting positions create unique experiences; and (2) they share a focus on experiences of those with multiple devalued and disadvantaged group memberships seen in early intersectionality theory and research.

Landrine, Klonoff, Alcaraz, Scott, and Wilkins (1995) tested the multiple-jeopardy-advantage hypothesis by examining a variety of factors including pay, interpersonal discrimination, and helping behaviors. For the multiple-jeopardy-advantage hypothesis to hold, individuals occupying lower status on multiple groups (e.g., Black, women, poor) should demonstrate the worst outcomes and those belonging to multiple high status groups (e.g., White, male, upper class) should report the best outcomes/advantages. By extension, the multiple-jeopardy-advantage hypothesis would also imply that those with mixed status (high status on one and low on another, e.g., White women or Black men) would fall between the first two groups. In their research, Landrine et al. (1995) found that women of color earned less than all other groups—supporting double jeopardy based on race and gender, and indicating that women of color were more likely to also be poor (another low-status group). Their findings also support multiple advantages because White men, regardless of age, earned more than members of any gender-race-age comparison group. It is important to note that recent studies find that this pattern of results continues to the present (Browne & Misra, 2003; Kim, 2006). Across studies of discrimination and attributions for success, the results were conclusive for multiple advantage privileging White men, but the evidence for multiple jeopardy was varied.

(p. 165) Given the mixed evidence, the authors concluded that the multiple jeopardy-advantage hypothesis was too simplistic to explain the multiple jeopardy experienced by those occupying intersecting marginalized social groups (Landrine et al., 1995). They note several limitations that may explain why multiple jeopardy, as opposed to multiple advantage, is more complicated than the linear interaction effect proposed by the multiple-jeopardy-

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

advantage hypothesis. First, the marginalized position of low-status groups is not equivalent. Thus, considering the specific low-status dimensions is essential in understanding phenomena like discrimination. For example, the nature, frequency, and severity of discrimination will vary if a woman is Black and gay versus if a woman is Black and disabled. Although each holds membership in three low-status groups, the unique intersection of these dimensions creates a social space that may differ considerably. Second, the multiple-jeopardy-advantage hypothesis does not account for the ways in which contextual differences influence discrimination. Using the same two women described earlier, the nature, severity, and frequency of the discrimination they face will differ if they are looking for employment, applying for public assistance, asking strangers for directions, or going on a blind date. Despite these limitations, double jeopardy and the multiple-jeopardy-advantage hypothesis can provide useful heuristics for conceptualizing how intersecting identities deny or convey privilege to some and disadvantage to others.

In the following sections, we review the literature related to the ways in which double and multiple jeopardy—occupation in multiple devalued social groups—increase the likelihood that one will encounter a variety of stressful life events (Benson, Wooldredge, Thistlethwaite & Fox, 2004; Frias & Angel, 2007). In particular, we examine how intersections of gender, race, social class, and sexual orientation lead to differences in poverty levels, mental health, and violence and victimization.

Multiple Social-Group Memberships and Poverty

There have been long-standing differences in the rates of pay across gender and ethnicity that persist to the present (Gaeddert, 2011). Differences in income are further exacerbated when the lowest economic strata are examined. Specifically, women are concentrated in the U.S. Bureau of Labor Statistic's three lowest wage occupations (Lichtenwalter, 2005), which translates into substantial gender inequality in poverty. The magnitude of the poverty gap is widened substantially when ethnicity is considered in conjunction with gender, leaving many more Black and Puerto Rican women living below the poverty line than other race-gender groups (Elmelech & Lu, 2004). Further, lesbian women of color typically earn less and are more likely to live in poverty than heterosexual men and women, White lesbian women, and gay men of color (Dang & Frazier, 2004).

Given that rates of poverty are unequally distributed across the population, the host of negative outcomes associated with living in poverty will also be distributed inequitably across groups. For example, women living in poverty, particularly poor women of color, report higher rates of general stress (American Psychological Association Task Force on Socioeconomic Status, 2007) and increased victimization, such as interpersonal violence (Stith, Smith, Penn, Ward & Tritt, 2004), sexual coercion, and assault by landlords (Reed, Collinsworth, & Fitzgerald, 2005; Short, 2008; Tester, 2008).

Multiple Social-Group Memberships and Mental Health Disparities

Being a member of a socioculturally marginalized group is associated with mental-health disparities thought to be the result of their increased incidence of stressful events and discrimination (Klonoff, Landrine, & Campbell, 2000). Namely, epidemiological studies have shown that women have higher rates of several psychological disorders (e.g., depression, posttraumatic stress, anxiety) than men (Dambrun, 2007, Kessler, 2003; Sachs-Ericsson & Ciarlo, 2000). Gay men and lesbian women also report increased rates of such disorders, compared to heterosexual men and women (APA, 2007; Mays & Cochran, 2001); when they experience stress and victimization based on their sexual orientation, they report even greater distress and impairment (Dunbar, 2006). Findings on racial disparities in mental health have varied, with some finding lower rates of some disorders, such as depression, among Hispanics and Blacks as compared to Whites, and other longitudinal studies demonstrating that once developed, mood and anxiety disorders are more persistent and debilitating among these ethnic minority groups (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). Similarly, those living in poverty not only have higher rates of diagnosable conditions including schizophrenia, depression, and posttraumatic stress, but they are also more likely to have multiple conditions simultaneously, which increases their severity and complicates treatment (APA, (p. 166) 2007; Gilman, Kawachi, Fitzmaurice, & Buka, 2002; Smith, 2005).

When examined via an intersecting lens of multiple group memberships, additional disparities emerge. For example, studies comparing differences across race often overlook differences across both gender and race. Baker, Buchanan, and Spencer (2010) noted that most studies on race and depression fail to note that Black women often

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

report higher rates of depression compared to White women and men of any race because they do not analyze across race-gender groups. Stress-related psychological disorders are higher among gay and lesbian people of color, particularly if they live in poverty (APA, 2007; Bowleg, Huang, Brooks, Black & Burkholder, 2003; Mays & Cochran, 2001). Similarly, victimization targeting both gender and race is associated with more severe psychological and physical health concerns (Berdahl & Moore, 2006; Buchanan, Bergman, Bruce, Woods, & Lichty, 2009; Buchanan & Fitzgerald, 2008; Moradi & Subich, 2003). In sum, the available body of research indicates that marginalized social-group membership is associated with more stressful life events and more negative mental-health outcomes, and that those with multiple intersecting marginalized group memberships are at greater risk overall.

Social-Group Memberships and Violence and Victimization

Violence and victimization also vary as a result of the relative marginalization across social groups and can be compounded for those belonging to multiple marginalized social groups. For example, women experience higher rates of interpersonal trauma (e.g., domestic violence, rape) than do men (Tjaden & Thoennes, (2000), which is associated with increased rates of posttraumatic stress, depression, and anxiety (Green et al., 2000; Kilpatrick et al., 2003; Krupnick et al., 2004). Similarly, ethnic minorities report greater numbers of traumatic events compared to Whites (Kalof, 2000), and sexual minorities are victimized at higher rates than are heterosexuals (Herek, 2009). Any traumatic event has the potential to impair one's well-being, but more frequent traumatic events and experiencing a greater variety of traumatic interpersonal events is associated with increased harm (Green et al., 2000; Krupnick et al., 2004). Research also supports that those who belong to intersecting marginalized groups are at increased risk of experiencing trauma and the trauma is more likely to target more than one marginalized identity, which may be particularly destructive (K. R. King, 2003, Settles, 2006). For example, lesbian women of color are targeted for severe forms of physical and sexual assault compared to other race-gender-sexual orientation groups (Dunbar, 2006). Further, greater functional impairment has been found among lesbians of color, potentially as a consequence of the more severe and violent forms of physical and sexual assault they often experience (Dunbar, 2006).

Multiple Social Groups and Intersectional Invisibility

The Black women's studies anthology, *All the Women Are White, All the Blacks Are Men, but Some of Us Are Brave* (Hull, Scott, & Smith, 1982) articulated the invisibility experienced by those who are located at the intersections of multiple marginalized social identities. *Intersectional invisibility* (Purdie-Vaughns & Eibach, 2008) is an additional model for considering the ways in which intersecting identities influence one's experiences and social position. This theory suggests that systems of oppression are sustained not only by elevating the status of certain social groups, but also by rendering members of other groups invisible. Defining the standard person as male (androcentrism), White (ethnocentrism), and heterosexual (heterocentrism) renders those that do not fit these categories less powerful than those that do. Moreover, subordinate groups are typically defined by their category of difference (from the norm or standard person) and then assumed to belong to normative groups across the remaining categories. Thus, Blacks (who differ from Whites) are assumed to be heterosexual men, and women (who differ from men) are assumed to be White hetereosexuals. As a result, those who belong to multiple subordinate social groups (Black women, gay men of color, lesbian women) fail to meet the prototypes of either the dominant groups or their respective marginalized groups, resulting in them typically being overlooked in popular discourse and rendered invisible. Because this invisibility is related to the absence of prototypes for either of the groups comprising their intersected identities, it is termed *intersectional invisibility* (Purdie-Vaughns & Eibach, 2008).

Intersectional invisibility is associated with disadvantages and advantages (Purdie-Vaughns & Eibach, 2008). Invisibility silences the voices and needs of those with intersecting marginalized identities across broad historical, cultural, political, and legal domains. This is manifested in *historical invisibility* when the experiences of group members (p. 167) with intersecting marginalized identities are absent from or distorted in historical narratives (Crenshaw, 1992). For example, Young and Spencer (2007) find that historical accounts of punishments inflicted on slaves in the United States reflect the punishments inflicted on Black male slaves, but rarely describe the ways in which punishments were both raced and gendered (such as raping or mutilating the breasts of Black female slaves). C*ultural invisibility* reflects the fact that those with intersecting marginalized identities also find that

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

cultural schemas and archetypes unfairly characterize and misrepresent them. For example, models of adolescent development and well-being are based on prototypes of heterosexual teens and fail to address the development of gay and lesbian young adults (Hunter & Mallon, 2000; Meyer, 2003). Similarly, models of development for sexual minorities are based on a White, male prototype; thus gay adolescents of color are poorly represented (Jamil, Harper, & Fernandez, 2009; Rosario, Schrimshaw, & Hunter, 2004), and the development of teen lesbians of color is altogether absent.

Disadvantages related to invisibility are also evident in political advocacy and legal jurisprudence (Purdie-Vaughns & Eibach, 2008). *Political invisibility* refers to the tendency of advocacy groups that serve marginalized people to focus on their prototypical constituents (e.g., women's movement focusing on White women's needs) and overlook unique needs of those with intersecting low-status identities (e.g., the needs of women of color). Advocacy groups may justify these oversights by rationalizing that they need to focus efforts on issues that affect the entire group, gains to the entire group will eventually improve the life circumstances of multiply marginalized group members, or assume other specialty advocacy groups are already addressing their needs (Strolovitch, 2007). These rationalizations result in little or no advocacy specific to the needs of multiply marginalized group members, despite claims that the advocacy group is serving all members of the larger subordinate group (Purdie-Vaughns & Eibach, 2008).

Legal invisibility refers to the variety of ways in which multiply marginalized people are poorly protected under the law. This includes assumptions about who can be victimized, the appropriate behavior of crime victims, discrimination statues that are ill-equipped to address claims based on more than one low-status category (*compound discrimination*; Carbado, 2000), and the fact that those who belong to multiple low-status groups are more likely to experience discrimination. Crenshaw (1991) found vast disparities in the prosecution and conviction of rape trials based on the race of the assaulted woman. Specifically, sexual crimes against Black women were investigated less rigorously, were less likely to be prosecuted and/or convicted, and, if convicted, the perpetrators were sentenced less severely than similar crimes against White women (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Donovan & Williams, 2002; Neville & Hamer, 2001).

Looking at sexual-harassment legal jurisprudence, Black women have been overrepresented as plaintiffs in sexual-harassment lawsuits, yet they continue to experience legal invisibility. Many of the first cases used to argue that sexual harassment constituted a form of gender discrimination, which was protected under Title VII of the Civil Rights Act (1964, 1991) were brought forward by Black women (e.g., *Barnes v. Costle*, 1977; *Meritor Savings Bank v. Vinson*, 1986). Nevertheless, evidence for race-gender bias continues at multiple levels including the informal and formal reporting process (Hernández, 2006), the types of discrimination charges that are considered admissible, and the outcome of cases, with women of color receiving less satisfactory legal redress compared to White women (Carbado, 2000).

Taken together, this implies that the marginalization of all women increases the likelihood that women of color will be ignored rather than overtly oppressed, providing some limited protection. In sum, occupation in multiple disadvantaged groups makes individuals vulnerable to negative experiences including those related to poverty, mental health, violence, and invisibility. Next, we discuss the research on group identifications.

Group Identifications

Intersectionality theory stresses the importance of considering individuals' multiple group memberships and multiple identities. The literature to date on individual and multiple social identities has focused on the benefits of identification as well as the potential for multiple identities to be in conflict with each other. In order to lay the groundwork for the more limited research on multiple identities, we begin with a discussion of the theory and research on single group identifications. Next, we describe how these theories and others have been extended in research on multiple identities and the development of models of multiple group identifications. We draw on and integrate research that examines individuals' simultaneous identification with groups (p. 168) based on different social-category memberships (e.g., gender and profession; race and gender) with research that examines their identification with multiple groups within the same social category (e.g., Asian and American cultural identities; White and Black racial identities).

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Social-Group Identifications and Psychological Well-Being

Theorists in the area of social identity have suggested that one key motivational factor that leads individuals to identify with social groups is that doing so enhances their self-esteem (Hogg, 2006). Part of the reason that social-group identification is thought to be associated with higher self-esteem is that identity formation produces a feeling of commitment and attachment to other members of the social group (Stets & Burke, 2000). Research generally supports the theorized positive association between social-group identification and psychological well-being (although there are some exceptions) for various types of identities. For example, studies have found that Black women and Latinas who were more identified with their racial or ethnic group report lower levels of depression and higher self-esteem (French & Chavez, 2010; Iturbide, Raffaelli & Carlo, 2009; Settles, Navarrete, Pagano, Abdou, & Sidanius, 2010). Similarly, women who were more identified with their gender reported more satisfaction with life and higher self-esteem (Schmitt, Branscombe, Kobrynowicz, & Owen, 2002; Settles, 2004). Women with a stronger lesbian identity reported more satisfaction with life (Fingerhut, Peplau, & Ghavami, 2005), and lesbian women, gay men, and bisexual individuals who felt more positively about their sexual minority identity reported higher self-esteem and life satisfaction as well as less depression (Mohr & Kendra, 2011).

In addition to social-group identification being directly associated with positive psychological outcomes, researchers have theorized that identifications can benefit psychological well-being through mediating and moderating roles. In particular, identity has been proposed to mitigate individuals' experiences of mistreatment, including prejudice, discrimination, and other forms of group-based devaluation and stress. The *rejection identification model* (Branscombe et al., 1999; Schmitt et al., 2002) proposes that increased group identification is a consequence of experiences of group-based discrimination. In turn, group identification is associated with greater psychological well-being; because identification often leads individuals to emphasize the positive features of their group, self-esteem and self-worth are increased (Branscombe, Schmitt, & Harvey, 1999; Tajfel & Turner, 1986). There is research that supports the relationships proposed by the rejection identification model. Studies have found that gender identification mediates relationship between psychological well-being and both group discrimination (Schmitt et al., 2002) and personal discrimination (Bourguignon, Seron, Yzerbyt, & Herman, 2006). Similarly, Branscombe and colleagues (1999) found that for African-Americans, perceived prejudice toward African-Americans was related to higher racial identification, which was related to positive psychological outcomes. These studies suggest that group identification may be a means of coping with the negative effects of experiencing discrimination and prejudice.

The *buffering hypothesis* (e.g., Sellers, Copeland-Linder, Martin, & Lewis, 2006; Yip, Gee, & Takeuchi, 2008) suggests that group identification buffers individuals from the negative impacts of discrimination and prejudice. Specifically, the theory proposes that the experience of group-based mistreatment will be related to more negative psychological outcomes for those individuals with low group identification (i.e., those who do not place importance on their group membership). In contrast, group-based mistreatment will not impact the outcomes of highly identified individuals. This theory views group identifications as providing members with resources to cope with various types of group-based stressors (Sellers & Shelton, 2003). In support of this theory, Sellers, Caldwell, Schmeelk-Cone, and Zimmerman (2003) found that discrimination was related to higher psychological distress for African-American adolescents with low or moderate racial identification. However, discrimination and distress were unrelated for individuals who were highly identified with their racial group. Similarly, Neblett, Shelton, and Sellers (2004) found that discrimination was linked to depression, stress, and anxiety for weakly identified African-Americans, but discrimination was unrelated to psychological outcomes for highly identified individuals. Focusing on gender, Sabik and Tylka (2006) found that the relationship between experiences of sexism and women's disordered eating was weakened only for those women with greater feminist identification. Rederstorff, Buchanan, and Settles (2007) also found that for White women with more feminist attitudes (i.e., greater feminist identification), the relationship **(p. 169)** between sexual harassment and psychological distress was buffered compared to White women with more traditional gender attitudes (i.e., lower feminist identification).

Despite the evidence of the protective buffering role of identity, some studies find that group identification exacerbates the relationship between negative experiences and subsequent psychological outcomes. Thoits (1991) suggested that negative events related to important identities are more threatening to one's sense of self compared to negative events associated with less-important identities. Thus, disruptions in important identities may intensify negative outcomes because they threaten the individual's self-concept. McCoy and Major (2003) found

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

that women low in gender identification experienced less depressed emotion and higher self-esteem if they were able to attribute a negative performance evaluation to a male evaluator's sexism than when they could not do so. However, for women high in gender identification, depressed mood and self-esteem were not buffered by attributions to sexism. Similarly, Iturbide and colleagues (2009) found that for Mexican-American college females, greater acculturative stress was related to more depressive symptoms only for women with a more central ethnic identity. In addition, Yip and colleagues (2008) found that for U.S.-born Asian individuals, whether ethnic identity was a buffering or exacerbating factor depended on the age of the individuals. Specifically, for those between 31 and 40 years or between 51 and 75 years, ethnic identity increased the negative effect of discrimination on mental health, perhaps because these are times of identity renegotiation. However, for those between 41 and 50, when life is relatively stable, ethnic identity buffered the impact of discrimination on mental health. Thus, group identification may act as a protective factor or a vulnerability factor in the relationship between negative group-based experiences and psychological outcomes; however, it is unclear when identification will play either role.

The *discounting hypothesis* (Crocker & Major, 1989) proposes that group identification is related to attributing negative events to discrimination or prejudice in specific situations. In this way, individuals who are highly identified with their group can discount negative treatment they experience as being a result of the prejudice of others rather than resulting from a negative or undesirable aspect of the self. Thus, the discounting hypothesis suggests that being able to view one's mistreatment as being a function of one's group membership may have positive outcomes for psychological well-being because the individual is able to make an external (rather than internal) attribution for mistreatment. In support of this model, research finds that when women attribute negative outcomes or feedback to sexism rather than to some internal cause (e.g., their own lack of ability), they report higher self-esteem and less depression (Major, Kaiser, & McCoy, 2003; Major, Quinton, & Schmader, 2003). Additionally, Major and colleagues (2003) found that women who are more identified with their gender are more likely to make attributions to sexism. Together, these studies offer support for the pattern of relationships proposed by the discounting hypothesis.

Thus, although membership in certain marginalized social groups and holding certain intersectional positions can lead women to experience more mistreatment and negative outcomes, group identification may sometimes protect individuals against the negative effects that can come with these marginalizing experiences. Researchers have offered various explanations for the protective effects of group identification, most of which may operate simultaneously. For example, Bourguignon et al. (2006) proposed that identification with other marginalized group members may help individuals to feel less isolated, particularly with respect to negative group-related experiences, like discrimination (Bourguignon et al., 2006). Others have suggested that group identification may facilitate information sharing and provide role models who assist individuals in developing a wider range of coping mechanisms to use when dealing with group-based mistreatment (Frable, Platt, & Hoey, 1998; Sellers et al., 2003). Further, because identification provides individuals with a sense of connection to others, it may permit group members to focus on positive aspects of the group in the face of prejudice (Sellers & Shelton, 2003). Finally, identification with marginalized groups may increase the likelihood that individuals will attribute negative experiences to the bias of others rather than to an internal, personal characteristic (Crocker & Major, 1989).

Applying Social Identity Research to Multiple Social-Group Identifications

Despite the abundant research on single identities, individuals simultaneously hold multiple identities that interact and intersect with each other to influence outcomes. In recognition of this fact, the rejection-identification model and the buffering hypothesis, which were developed to explain identification with single social groups, (p. 170) have been expanded in research on identification with multiple social groups. Jasinskaja-Lahti, Liebkind, and Solheim (2009) proposed the rejection-disidentification model, building on the rejection-identification model (Branscombe et al., 1999). The rejection-disidentification model proposes an identification process for individuals who have multiple groups with which they identify, such as biracial individuals (who identify with two racial groups) or immigrants (who identify with two national/cultural groups). The model suggests that when individuals are discriminated against by one of their in-groups, they may respond by disidentifying with that group and maintaining or increasing their identification with an alternate in-group. In their longitudinal research, Jasinskaja-Lahti et al. (2009) found that immigrants who experienced discrimination in their new country disidentified with that national identity but maintained their ethnic (i.e., country of origin) identity. Consistent with these results, other correlational research has found that immigrants in a multinational study who reported more ethnic discrimination reported a combination of characteristics that included high ethnic identification and low national identification (Berry,

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Phinney, Sam, & Velder, 2006).

Other research has examined the buffering hypothesis in relation to the dual identities of women scientists. In a sample of female-scientists, Settles, Jellison, and Pratt-Hyatt (2009) examined the protective role of the woman and scientist identities following experiences of interference between their woman and scientist identities, a multiple-group-related stressor. They found that interference was related to greater depression for women who decreased their level of gender identification over a two-year period of time; in contrast, interference was unrelated to depression two years later for women who increased their gender identification over time. They found a similar buffering pattern for change in scientist identification. Specifically, although interference was related to lower self-esteem for women who became less identified as scientists two years later, interference and self-esteem were unrelated for women who became more identified as scientists over time. Thus, increased identification with either group played a protective psychological role against conflict between the two identities.

Other work by Shih and colleagues illustrates that outcomes may depend on which of one's multiple identities are salient in a particular situation. In a study of Asian-American women, Shih, Pittinsky and Ambady (1999) found that those who had their Asian identity made salient performed best on a math test, whereas those who had their woman identity made salient performed worst (and those with no identity made salient performed in-between). Yet, when the study was performed in Canada, where the stereotype that Asians are good at math is weaker than in the United States, results indicated that although Asian Canadian women who had their woman identity made salient still performed the worst, those who had their Asian identity made salient also performed worse than the control group. These results and others suggest that making an identity associated with a positive stereotype salient may be an adaptive strategy that leads to positive outcomes (Shih, Sanchez, & Ho, 2010).

Multiple Social-Group Identifications: Conflict versus Harmony

In the past two decades, researchers have begun to attend seriously to the complexity of multiple- group identifications and to acknowledge the importance of individuals' multiple social positions. Yet, rather than focusing on how these multiple group memberships create unique social experiences, these theories and models have focused on how multiple identities may be organized and integrated by the individual. For example, Settles, Sellers, and Damas (2002) distinguished between whether student-athletes organized their two identities as separate (e.g., student *and* athlete) versus integrated (e.g., student-athletes). A component of these theories and models typically includes the extent to which the multiple identities conflict with each other or are integrated in a more positive manner (in terms of individuals' psychological outcomes). Identity conflict, or interference, occurs when individuals have difficulty enacting or meeting the expectation of two identities (Settles, 2004; Settles et al., 2002). When identities are in conflict, the individual perceives them as incompatible or in opposition to each other (Sacharin et al., 2009). In contrast, when identities facilitate each other—that is, enactment of one identity makes enactment of the other identity easier, then identity harmony (Brook, Garcia, & Fleming, 2008) or identity integration (Sacharin et al., 2009) occurs. Integrated identities, those that are in harmony with each other, are perceived to be compatible (Sacharin et al., 2009).

Research has consistently found that identity conflict/interference is associated with negative outcomes for a variety of identity combinations. For example, Settles and colleagues (2002) found that (p. 171) interference between the student and athlete identities was related to greater stress and depression. In a study of Black women, Settles (2006) found that interference in the Black identity from the woman identity was related to lower self-esteem and greater depression. Interference between the woman and scientist identity has also been associated with negative outcomes, including higher depression, lower self-esteem, and lower science performance perceptions, concurrently (Settles, 2004) and two years later (Settles et al., 2009). Research of individuals' constellation of multiple identities, rather than specific combinations of identities, Brook et al. (2008) found that greater identity harmony was related to greater psychological well-being. In another study of identity constellations, Settles, Jellison, and Poulsen (2013) found that individuals' evaluations of their identities as providing them with more resources than costs was related to greater psychological well-being.

Various explanations have been offered to account for the negative association between conflict/interference between identities and negative psychological outcomes. Identity conflict/interference may threaten an individual's sense of self if multiple aspects of the self create a sense of disorganization (Thoits, 1991). Interference/conflict may also reduce the use of effective coping strategies (Cooke & Rousseau, 1984) in part because it overtaxes

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

individuals' cognitive resources (Fried, Ben-David, Tiegs, Avital, & Yeverechyahu, 1998). Others have expanded this idea to theorize that conflicting identities make cognitive frame switching more difficult (e.g., Sacharin et al., 2009). Cognitive frame switching is the process of switching lenses through which the world is viewed; depending on the situational context, different identities comprising the self-concept may become more salient (Sacharin et al., 2009).

Multiple Social-Group Identifications: Integrative Theories and Models

Models have been offered to explain different ways that individuals might cognitively and psychologically organize multiple identities. Roccas and Brewer (2002) proposed a model of *multiple identity complexity* that includes four possible ways in which two social identities might be organized for an individual. Two identities may be *intersected* such that they create a unique compound group (e.g., middle-class lesbian). Alternatively, two identities may be *merged* in an additive manner (e.g., middle-class *and* lesbian). A third possibility is that one of the identities may *dominate* the other, such that only one of the identities is considered primary (e.g., lesbian). With *compartmentalization*, both of the identities are important components of the self but are separate from each other so that only one is activated at a time, depending on the social context (e.g., middle-class or lesbian depending on the situation). Roccas and Brewer (2002) note that these four types of multiple identity organization can be placed on a continuum in terms of their cognitive complexity or the extent to which potentially conflicting beliefs and values of identities are differentiated (i.e., recognized) and integrated (i.e., resolved). According to Roccas and Brewer (2002), intersecting identities are the least complex because differentiation is absent. At the other end, merged identities are the most complex because there is both differentiation and integration of potential conflicts between identities. Domination is the second least cognitively complex because any conflict between identities is suppressed and only the primary identity is acknowledged. Compartmentalized identities are the second most cognitively complex, because they permit differentiation but not integration of the identities. Roccas and Brewer (2002) note that these types of organization are not fixed; rather individuals may use different types of multiple identity organization at different times in their lives.

Amiot, de la Sablonnière, Terry, and Smith (2007) proposed a model to explain how individuals come to integrate multiple identities into the self. Following the process of categorizing multiple groups, the identities will become compartmentalized within the self; that is, individuals perceive themselves as belonging to both groups. At this stage, differences and distinctions between the groups are highly salient and the identities are not yet activated simultaneously. After compartmentalization, identities will become integrated in the final stage of multiple identity development. At this stage, individuals are aware of conflicts between identities but also can see links and similarities between identities. For positive psychological outcomes to result, individuals must be able to differentiate their identities while also integrating them into a coherent sense of self. Conflicts between identities can be resolved in one of two ways: the individual could develop a superordinate identity that reconciles the conflicts or the individual could recognize that the "conflicting" components of each identity contribute positively to her sense of self.

(p. 172) The process proposed by Amiot et al. (2007) overlaps somewhat with that proposed by Roccas and Brewer (2002). In both models, compartmentalization involves differentiation between two identities that are both felt to be important aspects of the self but that are not activated simultaneously. Their theories regarding the integration of identities differ somewhat because Amiot et al. (2007) view integrated identities as those in which both differentiation and resolution have taken place. Conversely, although Roccas and Brewer (2002) share this view of merged identities, they do not believe that intersected identities have these properties. However, Amiot et al. (2007) break integration into two types—restrictive integration and additive integration—which map onto Roccas and Brewer's (2002) conceptualization of intersection and merger, respectively. In both models, restrictive integration and intersection represent intersection as conceptualized by the feminist and sociologist literature. That is, the multiple identities are combined such that a unique identity is created. This produces a smaller in-group (e.g., only middle-class lesbians) than do additive integration or merger in which the in-group is comprised of everyone who belongs to both identities (e.g., all middle-class people and all lesbians). Both models view intersected or restrictively integrated identities as creating more in-group favoritism and out-group discrimination and prejudice than merged or additively integrated identities.

Although several models include the possibility of identities being intersected (Amiot et al., 2007; Roccas & Brewer,

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

2002), these theories have not considered intersecting identities in the way suggested by intersectionality theory (e.g. Cole, 2009). For example, Roccas and Brewer (2002) focus on how various forms of identity organization, including intersection, lead to attitudes about the out-group. Those with intersecting identities are theorized to be the least cognitively complex and engage in the most out-group bias. An intersectional perspective, however, would also emphasize how individuals see themselves in terms of their multiple identities as well as focusing on how intersected positions lead individuals to be treated in particular ways depending on the devaluation or privilege of their group memberships. In addition, existing models do not consider that some social-group memberships are more likely to become identities than others. Specifically, marginalized groups are more likely to be targets of discrimination and prejudice; as a result, these group memberships may become identities because of their heightened and repeated salience. Supporting this idea, qualitative research has found that individuals who hold multiple marginalized group memberships thought of themselves in terms of their marginalized identities before those that are privileged (Jones, 2009). Thus, it may be that multiple marginalized group memberships may become multiple identities that form the basis of intersected position (e.g., Black woman) more so than multiple privileged group memberships (e.g., White man).

These models also propose that individuals with intersected identities have a smaller in-group than individuals who integrate their identities in another way, such as with additive integration of identities (Amiot et al., 2007) or with merger (Roccas & Brewer, 2002). This assumes that individuals who see themselves in terms of an intersected position cannot simultaneously identify with the groups that comprise the intersection. For example, an Asian-American immigrant who sees herself as a "hyphenated" (i.e., intersected) individual may also identify as Asian and as American. Thus, although she may have a special affinity for other Asian-Americans, she may consider all Asian and Americans as in-group members. Such a conceptualization is consistent with a hierarchical model of identity that assumes some identities are more important than others but that many different identities may comprise the self-concept (Hogg, 2003).

Whereas the models proposed by Roccas and Brewer (2002) and Amiot et al. (2007) focus on the organization and integration of multiple identities related to different types of group memberships (e.g., gender and work identities; racial and gender identities), other models explain how individuals integrate identities of the same type (e.g., multiple racial or multiple cultural identities). Benet-Martínez and colleagues have proposed a model of *bicultural identity integration* to explain the acculturation experiences of immigrants (e.g., Benet-Martínez & Haritatos, 2005; Chen, Benet-Martínez, & Bond, 2008). This model explains biculturalism, the perceived compatibility and internalization of two cultural groups, as resulting from two cultural factors (Benet-Martínez & Haritatos, 2005). *Cultural conflict* refers to the degree to which the two identities are perceived by the individual to be in conflict versus in harmony. *Cultural distance* refers to the degree to which the individual compartmentalizes versus integrates ("hyphenates") their two cultural identities. Individuals with high bicultural identity integration are those with low cultural conflict and low cultural distance. That is, they view their (p. 173) cultural identities as integrated and in harmony. Cheng and Lee (2009), drawing upon the bicultural identity integration model, created the *multiracial identity integration* model to explain the experiences of biracial and multiracial individuals. The multiracial identity integration model has the same two components—conflict and distance—as the bicultural identity integration model. Whereas high identity integration is most like Roccas and Brewer's (2002) merger, low identity integration is most like compartmentalization.

Research has found that biracial individuals (Asian/White and Black/White) with higher identity integration report greater self-concept clarity (Lou, Lalonde, & Wilson, 2011). Other studies have found that bicultural individuals with higher identity integration display more creativity in tasks related to their multiple cultures, such as Asian-American's creation of dishes using both Asian and American ingredients (Cheng, Sanchez-Burks, & Lee, 2008). Additionally, when individuals integrate their identities, they "assimilate" better (Sacharin et al., 2009), that is they can more easily switch between the identities. However, when identities are cognitively separate, there is greater difficulty in cultural frame switching. Further, research by Chao, Chen, Roisman, and Hong (2007) found that bicultural individuals with more essentialist beliefs about race (i.e., beliefs that race is a meaningful category based on biological differences that confer specific properties) had more difficulty engaging in cultural frame switching. Other research, however, highlights the positive aspects of having low bicultural identity integration. Specifically, those lower in bicultural identity integration were more likely to resist group consensus in a judgment task, especially when the group judgment is incorrect (Mok & Morris, 2010). This is attributed to the tendency of those low in identity integration to engage in contrast responses to cultural norms.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Support has also been found for the proposed two dimensions of identity integration. For example, in a study of Chinese Americans, greater (bi)cultural conflict was found to be predicted by experiences of discrimination and difficult social interactions related to language and cultural expectations (Benet-Martínez & Haritatos, 2006). Greater (bi)cultural distance was related to feelings of cultural isolation and less competence in both cultures (Benet-Martínez & Haritatos, 2006). Additionally, greater multiracial pride has been associated with less distance between one's racial groups (Cheng & Lee, 2009). In sum, single and multiple identities often have a positive effect on psychological well-being. As discussed by various models and theories, perceiving one's multiple identities as having less conflict and greater integration makes positive outcomes especially likely. Following, we discuss additional ways in which an intersectional perspective can be applied to multicultural identities and considerations raised by intersectionality regarding multicultural identities.

Future Directions, Considerations, and Applications of an Intersectional Approach to Multiple Group Memberships and Identities

Some questions are listed in this section that we feel remain with respect to multiculturalism, multiple group memberships, and multiple identities. Our questions are informed by intersectionality theory and reflect ways in which this theory can contribute to the current thinking on multiculturalism, multiple group memberships, and multiple identity integration.

1. *How are processes related to multiple group memberships and multiple group identifications similar and different for specific combinations of groups/identities?*

One important issue for theorists to consider is whether processes related to group memberships, identity integration, and intersections are the same or similar for different combinations of identities. Research has noted that biracial individuals are perceived and stereotyped differently than monoracial individuals. Research by Sanchez and Bonam (2009) examined perceptions of hypothetical college applicants who were Black/White and Asian/White biracial individuals as compared to the corresponding monoracial groups. They found that Black/White individuals were perceived as less warm than Black individuals and White individuals, and Asian/White individuals were perceived as less warm and less competent than Asian individuals and White individuals. For both groups, the biracial individuals were viewed as less worthy of a minority scholarship than the corresponding monoracial minority. Further, although Sanchez and Bonam (2009) found that biracial individuals responded to negative feedback with decreased self-esteem when they disclosed their race, Shih, Bonam, Sanchez, and Peck (2007) found that biracial Asian/White individuals were less susceptible to racial stereotypes and more likely to believe that race is a social construction than monoracial individuals. Further, biracial **(p. 174)** women of various compositions are perceived to be exotic and sexually promiscuous (Root, 2004). There is also some theory to suggest that individuals with different biracial compositions are also viewed differently from each other. Wu (2002) notes that the pattern of interracial marriages is such that more Black men marry White women than the opposite, and more White men marry Asian women than the opposite. He suggests that these patterns reflect a racial hierarchy in which Whites are at the top, Asians are below them, and Blacks are below both groups. Thus, one might expect White/Asians to be perceived more positively than White/Blacks, and both groups viewed more positively that non-White biracial combinations. Thus, research in this area might investigate similarities and differences in identity processes, not only for multiracial individuals with different racial compositions, but also for individuals with different combinations of cultural backgrounds and those with different identity combinations unrelated to race and culture.

2. *How are multicultural, multiracial, and multiple identity individuals categorized? What are the implications of problems with their categorization by perceivers?*

Perceptions of bicultural and multicultural individuals, as well as individuals with other combinations of multiple identities, depend on how they are categorized. For multiracial individuals, categorization depends on how well their phenotypic characteristics (e.g., hair type, skin coloring) and behavior (e.g., language) fit the prototype of an individual from one or more racial groups. Researchers have noted that multiracial individuals challenge perceiver's ideas about race and the extent to which it is biologically based or socially constructed (e.g., Shih et al., 2007; Wu, 2002). To the extent that multiracial individuals are difficult to categorize, they may cause discomfort in perceivers, which may, in turn, lead perceivers to distance themselves from the multiracial individuals. This may account for the social isolation that monoracial individuals perceive to be characteristic of

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

multiracial children (Jackman, Wagner, & Johnson, 2001).

For multicultural but monoracial individuals, such as Asian immigrants to the United States or American-born Asian individuals, the difficulty in categorization by perceivers may be whether the Asian-American person is "American." Perceivers may experience discomfort because they are uncertain whether the Asian-American individual will speak English well, will hold Asian or American values, and so on. Cheryan and Monin (2005) observed that this "identity denial" applies to any non-White person who does not fit the prototype of American. Specifically, they found that Asian Americans, African Americans, and Hispanic Americans were all perceived by White participants to be less American than White Americans. Follow-up studies of Asian-Americans indicated that they responded to identity denial with attempts to reassert their American identity through displays of American cultural knowledge and practices.

Finally, for individuals with multiple identities of different types (e.g., Black women, female scientists, gay Latinos), the difficulty others have in categorizing them may depend largely on the visibility of their identities and the accessibility of stereotypes regarding intersecting identities. Consistent with the first idea, Jones (2009) found that individuals with visible and invisible marginalized identities realize they are "different" from the mainstream, but do so in different ways. Specifically, those with visible marginalized group memberships (e.g., racial minorities) felt different because of their different treatment by others, presumably based on how they are categorized. In contrast, those with invisible marginalized group memberships (e.g., sexual minorities) felt different internally rather than having their difference reflected by outsiders. In terms of stereotype accessibility, Goff et al. (2008) found that individuals were less accurate in guessing the gender of Black female faces than they were in guessing the gender of Black male faces and White female faces. The researchers attribute this to the fact that individuals associate Black with male, such that it is more difficult for them to correctly identify the gender of Black females. Thus, how identities, cultures, and racial group memberships appear to others may impact how individuals are categorized, stereotyped and treated, and the extent to which others avoid social interactions with these individuals.

3. *What is the impact of multiple disadvantaged identities/groups versus combinations with both privileged and devalued identities/groups?*

Researchers should also consider whether identity intersections are comprised of multiple disadvantaged identities versus a mix of advantaged and marginalized identities (versus multiple privileged identities; Cole, 2009; Shields, 2008). We note that much of the research on biculturalism and biracial identities has examined processes for individuals with one valued identity and one devalued identity (e.g., Asian-American bicultural individuals; Black/White **(p. 175)** biracial individuals). In contrast, the work on multiple identities and identity conflict has examined multiple devalued identities (e.g., Black women) and combinations in which some identities are valued (e.g., women scientists). When one's identities differ in status, this status inconsistency may lead individuals to employ different types of integration strategies than when one's identities share a devalued status. For example, when multiple identities are devalued (e.g., Black lesbian, Black/Mexican) the individual may be likely to embrace both in an intersected manner, particularly because awareness of issues of inequality related to one marginalized group membership may lead to an awareness of inequality related to other marginalized groups and their intersections. This double consciousness (or multiple consciousnesses; Gay & Tate, 1998; Rederstorff et al., 2007) may be greater for those with multiple devalued group memberships and identities.

However, when one or more group membership has higher status than others, individuals may be motivated to identify more strongly with some groups than others. Interestingly, the processes in this case seem to differ depending on whether one is considering multiple racial groups, multiple cultural groups, or multiple identities of different types. Because of the historical and cultural meaning of race, as well as its visibility, there is pressure of multiracial individuals to identify with their minority group—the group with the lowest social status, or more recently as multiracial (Root, 2004). For multicultural individuals, there are a range of possible integration processes that have been discussed at length within the acculturation literature (e.g., Berry et al., 2006), including identifying more with one identity than the other or integrating both into one's sense of self. A range of options may also exist for individuals with multiple identities from different categories. For individuals who want to be seen as legitimate members of a valued group, downplaying or disidentifying with the devalued group may achieve this aim. However, for individuals more identified with their devalued group, they may instead choose to maintain both identifications, either by intersecting them or embracing them in a compartmentalized manner. Clearly this is a complicated issue that needs further elucidation.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

4. *What are the situational influences on the salience and expression of group memberships and identities?*

Another consideration is whether individuals' organization of their identities is static. Most conceptualizations make allowances for the possibility that the organization of identities may change over time or under certain conditions. For example, Nguyen and Benet-Martínez (2007) argue that individuals with bicultural identity integration may employ different aspects of each identity in different contexts, such as a Mexican-American choosing to speak English in most situations but holding Mexican values and preferences at the same time. We extend such arguments to suggest that individuals might use their intersected identity as the lens through which they view the world in some situations, but in other situations they might be more strongly influenced by the individual identities comprising the intersection. An example would be a Black woman who frequently sees the world as a Black-woman, but at times employs the specific lens associated with being Black and other times sees the world in terms of gender. Similarly, we note that individuals typically hold more than two identities; thus, they may have different intersections activated in different contexts. This would be reflected in an individual moving between different constellations of identities, such as Black woman, female scientist, Black scientist, upper-class mother, and so on. Alternatively, certain identity intersections may be core to the self-concept such that they are always activated but additional identities may also become salient in different situations. Finally, the different patterns described earlier may vary at the level of the individual. Clearly this is an area in which research could be very productive and informative.

5. *How can the consideration of social contextual and historical factors inform our understanding of multiple groups and multiple identities?*

More generally, research on multiple groups, multiple identities, and multiculturalism should incorporate a greater consideration of social contextual and historical factors that impact perceptions of individuals with multiple identities, races, or cultures, their societal status and power, and how these things influence their treatment and opportunities. For example, we can consider the fact that attitudes about Black/White biracial individuals are related, in part, to the rape of Black female slaves by White slave owners. This resulted in Black individuals who varied in skin tone and also in the privileges they were afforded during slavery (Hunter, 2005). This history persists today in favoritism toward Blacks with lighter-skin tone (and other less phenotypically Black characteristics), such as their being less stereotyped (p. 176) with the negative characteristics assigned to Black people (e.g., lazy, unintelligent; Maddox & Gray, 2002), and receiving less discrimination (Klonoff & Landrine, 2000). However, although lighter-skinned Black women are perceived as more attractive than darker-skinned Black women (Hill, 2002), they are also more likely to be socially ostracized by other Black people (Hunter, 2005). These types of differences within the group of biracial Black/White individuals, and between biracial men and women, are important aspects of an intersectional perspective that should be considered, because they impact stereotyping, categorization, treatment, self-identification, behavior, and psychological outcomes.

Conclusion

Intersectionality theory can help researchers and theorists to expand their ideas about social-group memberships and social-group identifications. Intersectionality notes that we can only understand how belonging to a particular group shapes individuals' life experiences by considering their other group memberships simultaneously. As described earlier, some devalued group memberships tend to co-occur, resulting in cumulative disadvantage for individuals with those intersecting identities. In contrast, because identification with groups—even those that are devalued—often has a positive impact on psychological well-being, multiple identifications may promote positive psychological outcomes for individuals. At the same time, some identity combinations create conflict and subsequent negative psychological well-being, often because the identities have different stereotypes, norms, and expectations associated with them. This is true for multiple identities of the same type (e.g., Asian and American are both cultural identities) and multiple identities of different types (e.g., woman and scientist). Thus, intersectionality theory speaks to multiculturalism and cultural conflict. To date, models seeking to describe how identities are organized have focused on how intersecting identities might influence intergroup relations rather than how intersecting identities might influence self-conceptions and individual meaning making. There are numerous questions that remain to be addressed in this area, and, thus, there are tremendous opportunities for scholars to further consider how power, social position, and social hierarchies influence multiple social-group memberships

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

and multiple social-group identifications.

References

American Psychological Association, Task Force on Socioeconomic Status. (2007). *Report of the APA Task Force on Socioeconomic Status*. Washington, DC: American Psychological Association.

Amiot, C. E., de la Sablonnière, R., Terry, D. J., & Smith, J. R. (2007). Integration of social identities in the self: Toward a cognitive-developmental model. *Personality and Social Psychology Review*, *11*, 364–388.

Ashmore, R. D., Deaux, K., & McLaughlin-Volpe, T. (2004). An organizing framework for collective identity: Articulation and significance of multidimensionality. *Psychological Bulletin*, *130*, 80–114.

Baker, T. A., Buchanan, N. T., Spencer, T. (2010). Disparities and social inequities: Is the health of African American women still in peril? *Ethnicity & Disease*, *20*, 304–309.

Barnes v. Costle, 561 F.2d 983 (D.C. Cir. 1977).

Bavishi, A., Madera, J. M., & Hebl, M. R. (2010). The effect of professor ethnicity and gender on student evaluations: Judged before met. *Journal of Diversity in Higher Education*, *3*, 245–256.

Beal, F. M. (1970). Double jeopardy: To be Black and female. In T. Cade (Ed.), *The Black woman: An anthology* (pp. 90–100). New York: Signet.

Benet-Martínez, V., & Haritatos, J. (2005). Bicultural identity integration (BII): Components and psychosocial antecedents. *Journal of Personality*, *73*, 1015–1050.

Benson, M. L., Wooldredge, J., Thistlethwaite, A. B., & Fox, G. L. (2004). Correlation between race and domestic violence is confounded with community context. *Social Problems*, *51*, 326–342.

Berdahl, J. L., & Moore, C. (2006). Workplace harassment: Double jeopardy for minority women. *Journal of Applied Psychology*, *91*, 426–436.

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (2006). Immigrant youth: Acculturation, identity, and adaptation. *Applied Psychology: An International Review*, *55*, 303–332.

Bourguignon, D., Seron, E., Yzerbyt, V., & Herman, G. (2006). Perceived group and personal discrimination: Differential effects on personal self-esteem. *European Journal of Social Psychology*, *36*, 773–789.

Bowleg, L. (2008). When black + lesbian + woman ≠ black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*, *59*, 312–325.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among black lesbians. *Journal of Lesbian Studies*, *7*, 87–108.

Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*, *77*, 135–149.

Breslau, J. Kendler, K. S., Su, M., Gaxiola-Aguilar, S., & Kessler, R. C. (2005). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological Medicine*, *35*, 317–327.

Brewer, M. B. (1988). A dual process model of impression formation. In T. K. Srull, & R. S. Wyer Jr. (Eds.), *A dual process model of impression formation*. (pp. 1–36). Hillsdale, NJ, England: Erlbaum.

Brewer, M. B., & Lui, L. N. (1989). The primacy of age and sex in the structure of person categories. *Social Cognition*, *7*, 262–274.

(p. 177) Brook, A. T., Garcia, J. & Fleming, M. A. (2008). The effects of multiple identities on psychological well-

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

being. *Personality and Social Psychology Bulletin*, *34*, 1588–1600.

Browne, I. & Misra, J. (2003). The intersection of gender and race in the labor market. *Annual Review of Sociology*, *29*, 487–513.

Buchanan, N. T., Bergman, M. E., Bruce, T. A., Woods, K. C., & Lichty, L. F. (2009). Unique and joint effects of sexual and racial harassment on college students' well-being. *Basic and Applied Social Psychology*, *31*, 267–285.

Buchanan, N. T., & Fitzgerald, L. F. (2008). The effects of racial and sexual harassment on work and the psychological well-being of African American women. *Journal of Occupational Health Psychology*, *13*, 137–151.

Buchanan, N. T., Settles, I. H., & Woods, K. C. (2008). Comparing sexual harassment subtypes among black and white women by military rank: Double jeopardy, the jezebel, and the cult of true womanhood. *Psychology of Women Quarterly*, *32*, 347–361.

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivor's experiences with community service providers. *Journal of Interpersonal Violence*, *16*, 1239–1259.

Carbado, D. W. (2000). Race and sex in antidiscrimination law. In L. W. Levy, & K. L. Karst (Eds.), *Encyclopedia of the American constitution* (2nd ed.). New York: Macmillan.

Chao, M. M., Chen, J., Roisman, G., & Hong, Y. (2007). Essentializing race: Implications for bicultural individuals' cognition and physiological reactivity. *Psychological Science*, *18*, 341–348.

Chen, S. X., Benet-Martínez, V., & Bond, M. H. (2008). Bicultural identity, bilingualism, and psychological adjustment in multicultural societies: Immigration-based and globalization-based acculturation. *Journal of Personality*, *76*, 803–838.

Cheng, C., & Lee, F. (2009). Multiracial identity integration: Perceptions of conflict and distance among multiracial individuals. *Journal of Social Issues*, *65*, 51–68.

Cheng, C., Sanchez-Burks, J., & Lee, F. (2008). Connecting the dots within: Creative performance and identity integration. *Psychological Science*, *19*, 1178–1184.

Cheryan, S., & Monin, B. (2005). "Where are you really from?": Asian Americans and identity denial. *Journal of Personality and Social Psychology*, *89*, 717–730.

Civil Rights Act of 1964, Pub. L. No. 88–352, 78 Stat. 241 (1964).

Civil Rights Act of 1991, 42 U.S.C. §§ 1981, 2000e et seq.

Cole, E. R. (2008). Coalitions as a model for intersectionality: From practice to theory. *Sex Roles*, *59*, 443–453.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*, 170–180.

Combahee River Collective. (1995). Combahee River Collective statement. In B. Guy-Sheftall (Ed.), *Words of fire: An anthology of African American feminist thought* (pp. 232–240). New York: New Press. (Original work published 1977)

Cooke, R. A., & Rousseau, D. M. (1984). Stress and strain from family roles and work-role expectations. *Journal of Applied Psychology*, *69*, 252–260.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*, 1241–1299.

Crenshaw, K. W. (1992). Whose story is it anyway? Feminist and antiracist appropriations of Anita Hill. In T. Morrison (Ed.), *Race-ing justice, en-gendering power: Essays on Anita Hill, Clarence Thomas and the construction of social reality* (pp. 402–440). New York: Pantheon.

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D. K. Weisbert (Ed.), *Feminist legal theory:*

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Foundations (pp. 383–395). Philadelphia: Temple University Press. (Original work published 1989.)

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, *96*, 608–630.

Dambrun, M. (2007). Gender differences in mental health: The mediating role of perceived personal discrimination. *Journal of Applied Social Psychology*, *37*, 1118–1129.

Dang, A., & Frazier, S. (2004). *Black same-sex households in the United States*. Washington, DC: National Gay and Lesbian Task Force.

Demerath, L. (2006) Epistemological identity theory: Reconceptualizing commitment as self-knowledge. *Sociological Spectrum*, *26*, 491–517.

Diekman, A. B., & Eagly, A. H. (2000). Stereotypes as dynamic constructs: Women and men of the past, present, and future. *Personality and Social Psychology Bulletin*, *26*, 1171–1188.

Donovan, R. & Williams, M. (2002). Living at the intersection: The effects of racism and sexism on Black rape survivors. *Women & Therapy*, *25*, 95–105.

Dunbar, E. (2006). Race, gender, and sexual orientation in hate crime victimization: Identity politics or identity risk? *Violence and Victims*, *21*, 323–337.

Elmelech, Y. & Lu, H. (2004). Race, ethnicity, and the gender poverty gap. *Social Science Research*, *33*, 158–182.

Fingerhut, A. W., Peplau, L. A., & Ghavami, N. (2005). A dual-identity framework for understanding lesbian experience. *Psychology of Women Quarterly*, *29*, 129–139.

Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology*, *82*, 878–902.

Fiske, S. T., & Neuberg, S. L. (1990). A continuum of impression formation, from category-based to individuating processes: Influences of information and motivation on attention and interpretation. In M. P. Zanna (Ed.), *Advances in Experimental Social Psychology* (pp. 1–74). San Diego, CA: Academic.

Frable, D. E. S., Platt, L., & Hoey, S. (1998). Concealable stigmas and positive self-perceptions: Feeling better around similar others. *Journal of Personality and Social Psychology*, *74*, 909–922.

French, S. E. & Chavez, N. R. (2010). The relationship of ethnicity-related stressors and Latino ethnic identity to well-being. *Hispanic Journal of Behavioral Sciences*, *32*, 410–428.

Frias, S. M. & Angel, R. J. (2007). Stability and change in the experience of partner violence among low-income women. *Social Science Quarterly*, *88*, 1281–1306.

Fried, Y., Ben-David, H. A., Tiegs, R. B., Avital, N., & Yeverechyahu, U. (1998). The interactive effect of role conflict and role ambiguity on job performance. *Journal of Occupational and Organizational Psychology*, *71*(1), 19–27.

Gaeddert, W. (2011). Equal compensation discrimination. In M. A. Paludi, A. Carmen Jr., E. R. DeSouza (Eds.) *Praeger* **(p. 178)** *handbook on understanding and preventing workplace discrimination* (Vols. 1 & 2, pp. 45–61). Santa Barbara, CA: Praeger/ABC-CLIO.

Gay, C., & Tate, K. (1998). Doubly bound: The impact of gender and race on the politics of Black women. *Political Psychology*, *19*, 169–184.

Gilman, S. E., Kawachi, I., Fitzmaurice, G. M., & Buka, S. L. (2002). Socioeconomic status in childhood and the lifetime risk of major depression. *International Journal of Epidemiology*, *31*, 359–367.

Goff, P. A., Thomas, M. A., & Jackson, M. C. (2008). "Ain't I a woman?": Towards an intersectional approach to person perception and group-based harms. *Sex Roles*, *59*, 392–403.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of Traumatic Stress*, *13*, 271–286.

Haslam, S. A., Oakes, P. J., Reynolds, K. J., & Turner, J. C. (1999). Social identity salience and the emergence of stereotype consensus. *Personality and Social Psychology Bulletin*, *25*, 809–818.

Heilman, M. E. (1995). Sex stereotypes and their effects in the workplace: What we know and what we don't know. *Journal of Social Behavior & Personality*, *10*(6), 3–26.

Heilman, M. E. (2001). Description and prescription: How gender stereotypes prevent women's ascent up the organizational ladder. *Journal of Social Issues*, *57*, 657–674.

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*, *24*, 54–74.

Hernández, T. K. (2006). A Critical Race Feminism Empirical Research Project: Sexual Harassment and the Internal Complaints Black Box. *U. C. Davis Law Review*, *39*, 1235–1304.

Hill, M. E. (2002). Skin color and the perception of attractiveness among African Americans: does gender make a difference? *Social Psychology Quarterly*, *65*, 77–91.

Hogg, M. A. (2003). Social identity. In M. R. Leary and J. P. Tangney (Eds.), *Handbook of self and identity* (pp. 462–479). New York: Guilford Press.

Hogg, M. A. (2006). Social identity theory. In P. J. Burke (Ed.), *Contemporary social psychological theories* (pp. 111–136). Palo Alto, CA: Stanford University Press.

Hogg, M. A., & Abrams, D. (1990). Social motivation, self-esteem and social identity. In D. Abrams & M. A. Hogg (Eds.), *Social identity theory: Constructive and critical advances* (pp. 28–47) Hemel Hempstead, UK: Harvester Wheatsheaf, and New York: Springer-Verlag.

Hull, G. T., Scott, P. B., & Smith, B. (Eds.). (1982). *All the women are White, all the Blacks are men, but some of us are brave.* Old Westbury, NY: Feminist Press.

Hunter, M. (2005). *Race, gender, and the politics of skin tone*. New York: Routledge-Taylor Francis.

Hunter, J. & Mallon, G. P. (2000). Lesbian, gay, and bisexual adolescent development: Dancing with your feet tied together. In B. Greene & G. Croom (Eds.), *Education, research, and practice in lesbian, gay, bisexual, and transgendered psychology: A resource manual*, (Vol. 5, pp. 226–243). Thousand Oaks, CA: Sage.

Hurtado, A., & Sinha, M. (2008). More than men: Latino feminist masculinities and intersectionality. *Sex Roles*, *59*, 337–349.

Iturbide, M. I., Raffaelli, M., & Carlo, G. (2009). Protective effects of ethnic identity on Mexican American college students' psychological well-being. *Hispanic Journal of Behavioral Sciences*, *31*, 536–552.

Jackman, C. F., Wagner, W. G., & Johnson, J. T. (2001). The attitudes toward multiracial children scale. *Journal of Black Psychology*, *27*, 86–99.

Jamil, O. B, Harper, G. W. & Fernandez, M. I. (2009). Sexual and ethnic identity development among gay–bisexual–questioning (GBQ) male ethnic minority adolescents. *Cultural Diversity and Ethnic Minority Psychology*, *15*, 203–221.

Jasinskaja-Lahti, I., Liebkind, K., & Solheim, E. (2009). To identify or not to identify? National disidentification as an alternative reaction to perceived ethnic discrimination. *Applied Psychology: An International Review*, *58*, 105–128.

Jeffries, V., & Ransford, H. E. (1980). *Social stratification: A multiple hierarchy approach*. Boston: Allyn & Bacon.

Jordan-Zachery, J. S. (2007). Am I a Black woman or a woman who is Black? A few thoughts on the meaning of

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

intersectionality. *Politics & Gender 3*, 254–263.

Jones, S. R. (2009). Constructing identities at the intersections: An autoethnographic exploration of multiple dimensions of identity. *Journal of College Student Development*, *50*(3), 287–304.

Kalof, L. (2000). Ethnic differences in female sexual victimization. *Sexuality & Culture*, *4*, 75–98.

Kessler, R. C. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, *74*, 5–13.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*, *71*, 692–700.

Kim, J. (2006). Gender inequality in the U.S. Labor Market: Evidence from the 2000 Census. In M. F. Karsten (Ed.), *Gender, race, and ethnicity in the workplace: Issues and challenges for today's organizations* (pp. 269–290). Westport, CT: Praeger.

King, D. K. (1988). Multiple jeopardy, multiple consciousness: The context of Black feminist ideology. *Signs*, *14*, 42–72.

King, K. R. (2003). Racism or sexism? Attributional ambiguity and simultaneous memberships in multiple oppressed groups. *Journal of Applied Social Psychology*, *33*, 223–247.

Kite, M. E., & Deaux, K. (1987). Gender belief systems: Homosexuality and the implicit inversion theory. *Psychology of Women Quarterly*, *11*, 83–96.

Klonoff, E., & Landrine, H. (2000). Is skin color a marker for racial discrimination? Explaining the skin color-hypertension relationship. *Journal of Behavioral Medicine*, *23*, 329–338.

Klonoff, E. A., Landrine, H., & Campbell, R. (2000). Sexist discrimination may account for well-known gender differences in psychiatric symptoms. *Psychology of Women Quarterly*, *24*, 93–99.

Krupnick, J. L., Green, B. L., Stockton, P., Goodman, L. A., Corcoran, C. B., & Petty, R. M. (2004). Mental health effects of adolescent trauma exposure in a female college sample: Exploring differential outcomes based on experiences of unique trauma types and dimensions. *Psychiatry: Interpersonal and Biological Processes*, *67*, 264–279

Landrine, H. (1985). Race × class stereotypes of women. *Sex Roles*, *13*, 65–75.

(p. 179) Landrine, H., Klonoff, E. A., Alcaraz, R., Scott, J., & Wilkins, P. (1995). Multiple variables in discrimination. In B. Lott and D. Maluso (Eds.), *The social psychology of interpersonal discrimination* (pp. 183–224). New York: Guilford.

Lichtenwalter, S. (2005). Gender poverty disparity in US cities: Evidence exonerating female-headed families. *Journal of Sociology and Social Welfare*, *32*(2), 75–96.

Lott, B., & Saxon, S. (2002). The influence of ethnicity, social class and context on judgments about U. S. women. *The Journal of Social Psychology*, *142*, 481–499.

Lou, E., Lalonde, R. N., & Wilson, C. (2011). Examining a multidimensional framework of racial identity across different biracial groups. *Asian American Journal of Psychology*, *2*, 79–90.

Maddox, K. B., & Gray, S. A. (2002). Cognitive representations of Black Americans: Reexploring the role of skin tone. *Personality and Social Psychology Bulletin*, *28*, 250–259.

Major, B., Kaiser, C. R., & McCoy, S. K. (2003). It's not my fault: When and why attributions to prejudice protect self-esteem. *Personality and Social Psychology Bulletin*, *29*, 772–781.

Major, B., Quinton, W. J., & Schmader, T. (2003). Attributions to discrimination and self-esteem: Impact of group identification and situational ambiguity. *Journal of Experimental Social Psychology*, *39*, 220–231.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, *91*, 1869–1876.

McCoy, S. K., & Major, B. (2003). Group identification moderates emotional responses to perceived prejudice. *Personality and Social Psychology Bulletin*, *29*(8), 1005–1017.

Meritor Savings Bank v. Vinson, 477 US 57 (1986).

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697.

Mohr, J. J., & Kendra, M. S. (2011). Revision and extension of a multidimensional measure of sexual minority identity: The lesbian, gay, and bisexual identity scale. *Journal of Counseling Psychology*, *58*, 234–245.

Mok, A., & Morris, M. W. (2010). An upside to bicultural identity conflict: Resisting groupthink in cultural ingroups. *Journal of Experimental Social Psychology*, *46*, 1114–1117.

Moradi, B., & Subich, L. M. (2003). A concomitant examination of the relations of perceived racist and the sexist events to psychological distress for African American women. *The Counseling Psychologist*, *31*, 451–469.

Neblett, E. W., Shelton, J. N., & Sellers, R. M. (2004). The role of racial identity in managing daily hassles. In G. Philogene (Ed.). *Race and identity: The legacy of Kenneth Clark*. Washington, DC: American Psychological Association Press.

Neville, H. A., & Hamer, J. (2001). “We make freedom”: An exploration of revolutionary Black feminism. *Journal of Black Studies*, *31*, 437–461.

Nguyen, A. D., & Benet-Martínez, V. (2007). Biculturalism unpacked: Components, measurement, individual differences, and outcomes. *Social and Personality Psychology Compass*, *1*, 101–114.

Niemann, Y. F., Jennings, L., Rozelle, R. M., Baxter, J. C., & Sullivan, E. (1994). Use of free responses and cluster analysis to determine stereotypes of eight groups. *Personality and Social Psychology Bulletin*, *20*, 379–390.

Purdie-Vaughns, V., Eibach, R. P. (2008). Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex Roles*, *59*, 377–391.

Rederstorff, J. C., Buchanan, N. T., Settles, I. H. (2007). The moderating roles of race and gender role attitudes in the relationship between sexual harassment and psychological well-being. *Psychology of Women Quarterly*, *31*, 50–61.

Reed, M. E., Collinsworth, L. L., & Fitzgerald, L. F. (2005). There’s no place like home: Sexual harassment of low income women in housing. *Psychology, Public Policy, and Law*, *11*, 439–462.

Reid, L. D. (2010). The role of perceived race and gender in the evaluation of college teaching on RateMyProfessors.com. *Journal of Diversity in Higher Education*, *3*, 137–152.

Roccas, S., & Brewer, M. (2002). Social identity complexity. *Personality and Social Psychology Review*, *6*, 88–106.

Root, M. P. P. (2004). From exotic to a dime a dozen. In A. R. Gillem & C. A. Thompson (Eds.), *Biracial women in therapy: Between the rock of gender and the hard place of race* (pp. 19–32). New York: Haworth Press.

Rosario, M., Schrimshaw, E. W. & Hunter, J. (2004). Ethnic/Racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology*, *10*, 215–228.

Sabik, N. J., & Tylka, T. L. (2006). Do feminist identity styles moderate the relation between perceived sexist events and disordered eating? *Psychology of Women Quarterly*, *30*, 77–84.

Sacharin, V., Lee, F., & Gonzalez, R. (2009). Identities in harmony: Gender-work identity integration moderates frame switching in cognitive processing. *Psychology of Women Quarterly*, *33*, 275–284.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Sachs-Ericsson, N., & Ciarlo, J. A. (2000). Gender, social roles, and mental health: An epidemiological perspective. *Sex Roles*, *43*, 605–628.

Sanchez, D. T., & Bonam, C. M. (2009). To disclose or not to disclose biracial identity: The effect of biracial disclosure on perceiver evaluations and target responses. *Journal of Social Issues*, *65*, 129–149.

Schmitt, M. T., Branscombe, N. R., Kobrynowicz, D., & Owen, S. (2002). Perceiving discrimination against one's gender group has different implications for well-being in women and men. *Personality and Social Psychology Bulletin*, *28*, 197–210.

Sellers, R. M., Caldwell, C. H., Schmeelk-Cone, K. H., & Zimmerman, M. A. (2003). The role of racial identity and racial discrimination in the mental health of African American young adults. *Journal of Health and Social Behavior*, *44*, 302–317.

Sellers, R. M., Copeland-Linder, N., Martin, P. P., & Lewis, R. L. (2006). Racial identity matters: The relationship between racial discrimination and psychological functioning in African American adolescents. *Journal of Research on Adolescence*, *16*, 187–216.

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology*, *84*, 1079–1092.

Settles, I. H. (2004). When multiple identities interfere: The role of identity centrality. *Personality and Social Psychology Bulletin*, *30*, 487–500.

Settles, I. H. (2006). Use of an intersectional framework to understand Black women's racial and gender identities. *Sex Roles*, *54*, 589–601.

(p. 180) Settles, I. H., Jellison, W. A., & Poulsen, J. (2013). *The mediating role of identity evaluations in the relationship between the prominence of identities and psychological well-being*. Unpublished manuscript.

Settles, I. H., Jellison, W. A., & Pratt-Hyatt, J. S. (2009). Identification with multiple social groups: The moderating role of identity change over time among women scientists. *Journal of Research in Personality*, *43*, 856–867.

Settles, I. H., Navarrete, C. D., Pagano, S., Abdou, C., & Sidanius, J. (2010). Ethnic identity and depression among African-American women. *Cultural Diversity & Ethnic Minority Psychology*, *16*, 248–255.

Settles, I. H., Pratt-Hyatt, J. S., & Buchanan, N. T. (2008). Through the lens of race: Black and white women's perceptions of womanhood. *Psychology of Women Quarterly*, *32*, 454–468.

Settles, I. H., Sellers, R. M., & Damas Jr., A. (2002). One role or two? The function of psychological separation in role conflict. *Journal of Applied Psychology*, *87*, 574–582.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles*, *59*, 301–311.

Shih, M., Bonam, C., Sanchez, D., & Peck, C. (2007). The social construction of race: Biracial identity and vulnerability to stereotypes. *Cultural Diversity and Ethnic Minority Psychology*, *13*, 125–133.

Shih, M., Pittinsky, T. L., & Ambady, N. (1999). Stereotype susceptibility: Identity salience and shifts in quantitative performance. *Psychological Science*, *10*, 81–84.

Shih, M., Sanchez, D. T., & Ho, G. C. (2010). Costs and benefits of switching among multiple social identities. In R. Crisp (Ed). *The psychology of social and cultural diversity* (pp. 62–83). Hoboken, NJ: Wiley-Blackwell.

Short, A. K. (2008). Slaves to rent: Sexual harassment in housing as involuntary servitude. *Nebraska Law Review*, *86*, 838–894.

Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, *60*, 687–696.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, *63*, 224–

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

237.

Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review, *Aggression and Violent Behavior*, *10*, 65–98.

Strolovitch, D. Z. (2007). *Affirmative advocacy: Race, class, and gender in interest group politics*. Chicago, IL: University of Chicago Press.

Tajfel, H. & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 7–24). Chicago: Nelson-Hall.

Tester, G. (2008). An intersectional analysis of sexual harassment in housing. *Gender & Society*, *22*, 349–366.

Thoits, P. A. (1991). On merging identity theory and stress research. *Social Psychology Quarterly*, *54*, 101–112.

Thoits, P. A. (1995). Identity-relevant events and psychological symptoms: A cautionary tale. *Journal of Health and Social Behavior*, *36*, 72–82.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of physical violence: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention.

White, J. B., & Gardner, W. L. (2009). Think women, think warm: Stereotype content activation in women with a salient gender identity, using a modified Stroop task. *Sex Roles*, *60*, 247–260.

Williams, D. R., Lavizzo-Mourey, R., Warren, R.C. (1994). The concept of race and health status in America. *Public Health Reports 109*, 26–41.

Wu, F. H. (2002). *Yellow: Race in America beyond black and white*. New York: Basic Books.

Yip, T., Gee, G. C., & Takeuchi, D. T. (2008). Racial discrimination and psychological distress: The impact of ethnic identity and age among immigrant and united states-born Asian adults. *Developmental Psychology*, *44*, 787–800.

Young, V. D. & Spencer, Z. (2007). Multiple jeopardy: The impact of race, gender, and slavery on the punishment of women in antebellum America. In M. Bosworth & J. Flavin (Eds.), *Race, gender, and punishment: From colonialism to the War on Terror* (pp. 65–76). Piscataway, NJ: Rutgers University Press.

Isis Settles

Isis Settles is Associate Professor of Psychology at Michigan State University.

Nicole T. Buchanan

Nicole T. Buchanan is Associate Professor of Psychology at Michigan State University.

PRINTED FROM OXFORD HANDBOOKS ONLINE (www.oxfordhandbooks.com). (c) Oxford University Press, 2014. All Rights Reserved. Under the terms of the licence agreement, an individual user may print out a PDF of a single chapter of a title in Oxford Handbooks Online for personal use (for details see Privacy Policy).
Subscriber: Oxford University Press - Master Gratis Access; date: 09 February 2015

Journal of Experimental Social Psychology 48 (2012) 1162–11167

Contents lists available at SciVerse ScienceDirect

Journal of Experimental Social Psychology

journal homepage: www.elsevier.com/locate/jesp

Reports

Failure is not an option for Black women: Effects of organizational performance on leaders with single versus dual-subordinate identities

Ashleigh Shelby Rosette [a,*], Robert W. Livingston [b,1]

[a] The Fuqua School of Business, Duke University, 100 Fuqua Drive, P.O. Box 90120, Durham, NC 27708-0120, USA
[b] Kellogg School of Management, Northwestern University, 2001 Sheridan Rd., Evanston, IL 60208, USA

ARTICLE INFO

Article history:
Received 27 November 2011
Revised 26 April 2012
Available online 11 May 2012

Keywords:
Leadership
Diversity
Double jeopardy
Race
Gender
Intersectionality

ABSTRACT

We contribute to a current debate that focuses on whether individuals with more than one subordinate identity (i.e., Black women) experience more negative leader perceptions than do leaders with single-subordinate identities (i.e., Black men and White women). Results confirmed that Black women leaders suffered *double jeopardy*, and were evaluated more negatively than Black men and White women, but only under conditions of organizational failure. Under conditions of organizational success, the three groups were evaluated comparably to each other, but each group was evaluated less favorably than White men. Further, leader typicality, the extent to which individuals possess characteristics usually associated with a leader role, mediated the indirect effect of leader race, leader gender, and organizational performance on leader effectiveness. Taken together, these results suggest that Black women leaders may carry a burden of being disproportionately sanctioned for making mistakes on the job.

© 2012 Elsevier Inc. All rights reserved.

Over the past few decades, the interest in studying female and racial minority leaders has increased significantly. The perceived incompatibility between the female gender role and the leader prototype, which has been traditionally defined as masculine, has been shown to have deleterious effects for women when their leadership capabilities are evaluated (e.g., Eagly, Johannesen-Schmidt, & Engen, 2003; Eagly & Karau, 1991, 2002; Heilman, Block, Martell, & Simon, 1989; Schein, 1973). Similarly, studies have shown that Blacks are generally perceived as less effective leaders than Whites because negative stereotypes are at odds with expected leadership characterizations (Beatty, 1973; Ford, Kraiger, & Schechtman, 1986; Greenhaus, Parasuraman, & Wormley, 1990; Knight, Hebl, Foster, & Mannix, 2003; Powell & Butterfield, 1997). Because White men are generally viewed as typical leaders (Rosette, Leonardelli, & Phillips, 2008), nearly all previous research that has focused concurrently on diversity and leadership has compared White men to White women when considering gender, and has compared White men to Black men when considering race. Moreover, the overwhelming majority of this research has shown that White men have clear advantages over both groups when perceptions of leadership are considered. To date, little research has explicitly investigated how leadership perceptions differ for individuals with dual-subordinate identities (i.e., Black women).

The current study sought to fill that gap and examine whether leader perceptions vary as a function of single- versus dual-subordinate identities. Specifically, our focal question is the following: How do Black women leaders fare relative to Black men leaders or White women leaders? One possibility is that Black women leaders fare worse than either Black men or White women because they possess a dual- as opposed to single-subordinate identity. The term *double jeopardy* has been used to describe the heightened disadvantage of Black women due to the adverse consequences of the *Black* and *female* subordinate identities (Almquist, 1975; Beale, 1970; Bowleg, 2008; Crenshaw, 1989; Epstein, 1973; Settles, 2006). This double jeopardy perspective is consistent with *recognition-based processes of leadership* which focus on the extent to which the characteristics of a particular target are congruent with the characteristics of a typical leader (Lord & Maher, 1991). That is, leader typicality comprises the modal or central tendencies of a leader and those targets whose characteristics are consistent with such tendencies are *recognized* as typical leaders (Lord, Foti, & DeVader, 1984). Conceptually, recognition-based processes are predicated on schema or cognitive representations used to simplify the process by which typical leadership is recognized. Because the schematic representation of a typical leader does not encompass Blacks when race is considered or women when gender is considered, Black women may be disadvantaged relative to other groups that share a greater degree of schematic overlap.

In support of the double jeopardy perspective, empirical studies have found that Whites are perceived as more typical leaders than Blacks (Chung-Herrera & Lankau, 2005; Rosette et al., 2008) and men are perceived as more typical leaders than women (Brenner, Tomkiewicz, & Schein, 1989; Heilman et al., 1989; Nye & Forsyth,

* Corresponding author. Fax: +1 919 681 6244.
E-mail addresses: arosette@duke.edu (A.S. Rosette), rwlivingston@kellogg.northwestern.edu (R.W. Livingston).
[1] Fax: +1 847 491 8896.

0022-1031/$ – see front matter © 2012 Elsevier Inc. All rights reserved.
doi:10.1016/j.jesp.2012.05.002

1991; Schein, 1973, 2001; Scott & Brown, 2006; Willemsen, 2002). It logically follows that Black women would be perceived as the least typical leaders because neither their race nor their gender overlap with typical leader expectations. Moreover, those leaders whose characteristics are inconsistent with leader typicality are less easily categorized as leaders and are evaluated unfavorably when compared to leaders who possess high leader typicality (Foti, Fraser, & Lord, 1982; Foti & Lord, 1987; Lord, DeVader, & Alliger, 1986; Phillips, 1984; Scott & Brown, 2006). This double jeopardy perspective is most keenly supported by the extreme under-representation of Black women in leader and executive positions (Bell & Nkomo, 2001; Blake, 1999; Parker & ogilvie, 1996; Sanchez-Hucles & Davis, 2010).

Counter to the double jeopardy paradigm, an alternative perspective is that their double subordinate identities can, in some cases, attenuate bias against Black women relative to White women or Black men. Just as in mathematics the multiplication of two negative integers yields a positive result, the social argument is that having two subordinate identities can actually yield more positive outcomes than having a single-subordinate identity. In particular, the combination of subordinate race and gender identities can produce 'intersectional invisibility' resulting in a peripheral status that is not necessarily accompanied by negative outcomes (Purdie-Vaughns & Eibach, 2008). That is, because Black women do not fit the exemplar of *either* of their respective subordinate groups, they may be able to escape from negative outcomes directed toward more typical *women* (i.e., White women) and *Blacks* (i.e., Black men), and engage in more typical leader behaviors without being perceived negatively for doing so.

Recent findings on leader typicality support this contention. When compared to both White women leaders and Black men leaders who exhibited agentic behaviors and emotions, characteristics consistent with leader typicality (see Eagly & Karau, 2002), Black women leaders were conferred higher leader status (Livingston, Rosette, & Washington, 2012). Similarly, Black career women who displayed dominance, another characteristic that is consistent with typical leader characteristics, were shown to be more likeable and more hirable than identically-described White women or Black men (Hall et al., 2012). These findings support the intersectional invisibility paradigm and suggest that the combination of being both Black and female enables Black women to express typical leader behaviors without penalty (in a way that White women and Black men cannot) because of their peripheral status in each of their respective subordinate groups. However, this previous research did not examine whether such favorable perceptions of Black women would occur when one of the most rudimentary functions of leadership is considered: organizational performance (Meindl & Ehrlich, 1987; Meindl, Ehrlich, & Dukerich, 1985).

According to *inferential-based processes of leadership*, a predominant leadership theory that focuses on organizational performance, leadership is frequently inferred from organizational outcomes ascribed to the individual such that there is a positive associative link between perceived leadership and level of organizational performance (Lord & Maher, 1991; Meindl & Ehrlich, 1987; Meindl et al., 1985). Specifically, positive performance has been shown to be linked to leaders whereas negative performance has been shown to be indicative of non-leadership (Rush, Phillips, & Lord, 1981; Shamir, 1992). This suggests that positive organizational performance may be perceived as consistent with a typical leader; whereas negative organizational performance may be perceived as possessing low leader typicality.

As applied to our work, when inference and recognition-based processes are considered concurrently, Black women may be differentially evaluated, relative to other groups, depending on whether their organizational performance is positive or negative. Negative performance can be especially damaging to Black women because their two subordinate identities generally do not allow for a positive attribution for the negative behavior. In other words, the propensity to negatively evaluate Black women as ineffective leaders when unsuccessful organizational outcomes occur (inference-based processes) will be bolstered by the categorization of Black women as unlikely, atypical leaders (recognition-processes). Because Black women possess not just one, but two, subordinate identities – neither of which has been shown to be particularly typical of the leader role – they will be perceived most negatively in a context of failure when compared to Black men and White women. In particular, three factors – race (Black), gender (women), and performance (failure) – are consistent because none of them is indicative of typical leadership. This system of matching that we predict will occur between recognition- and inference-based processes is consistent with the conceptual framework of comprehension goals whereby prototypical and non-prototypical categorizations are used when they aid comprehension (i.e., when the social category is in agreement with the outcome), but is not applied when comprehension is inhibited (Kunda & Spencer, 2003).

However, when Black women experience success, the combination of (negative) recognition-based processes and (positive) inference-based processes will contradict one another and not fit together. This contradiction should hinder comprehension and limit the incorporation of non-typical characteristics in the evaluative process. Although her performance outcome would be indicative of positive leader characteristics perceived as typical, the social groups to which she belongs may be recognized as ineffective leaders because her subordinate identities are not typical of the leader role. When recognition- and inference-based processes do not align, Black women will be perceived comparably to other social groups who also possess a negative subordinate identity that is not congruent with a positive successful performance. For Black men who succeed, their race will be perceived as incompatible with performance outcomes. Similarly, the same incompatibility will occur for successful White women because of their gender. Thus, Black women, Black men, and White women should be evaluated comparably when successful because for each group, the recognition processes are in contradiction with the inferential process. For White men, however, recognition processes augment inferential processes as three factors – race (White), gender (men), and performance (success) – are all consistent. Thus, White men should be evaluated the most favorably under conditions of organizational success.

In sum, we predict a three-way interaction between leader gender, leader race, and organizational performance such that Black women will be perceived negatively relative to Black men or White women, but only when their organization is not successful. Furthermore, we predict that this proposed moderation will be mediated by leader typicality. That is, the extent to which a target exhibits the characteristics consistent with a leader will mediate the predicted interaction between organizational performance, leader race, and leader gender on perceived leader effectiveness.

Methods

Participants and study design

A total of 228 participants (50% women) which comprised undergraduate students (164), graduate students (41), and working adults (23) were recruited in the student union of a southeastern university to participate in a 35 minute long experimental session including this study in exchange for $10US. Of these participants, 98 were White, 74 were Black, 35 were Asian, 8 were Hispanic, and 13 classified their race as "Other." Participants' student status, race, and gender did not qualify the results and accordingly will not be considered further. At the time of the study, most of the participants were employed full-time (25%), part-time (45%), or were currently unemployed, but had worked previously (27%). Thus, most participants likely had exposure to leader roles in organizational settings. The participants had an average age of 23.90 (SD = 7.43) years and 5.80 (SD = 6.88) years of work experience. The study consisted of a 2 (organizational performance:

failure, success) × 2 (race: Black, White) × 2 (gender: male, female) between-participants factorial design.

Procedure

Participants were told that the purpose of the study was to investigate how people make inferences from the newspaper articles they read. They were informed that they would be reading an article recently printed in a national news outlet and then answer questions about the article. The article was about a corporation, its senior executive officer, and the corporation's recent performance. Thus, the article contained the experimental manipulations for organizational performance, leader gender, and leader race, described below. Participants were randomly assigned to read one of the eight versions of the article before completing the post questionnaire. Participants were then debriefed and dismissed.

Organizational performance

To manipulate the corporation's performance as successful, the company's earnings were described in the article as having increased and a graph noting a positive percentage change in earnings over the past 5 months was also included. For the unsuccessful conditions, the earnings were described as having decreased and the graph depicted a continual decline in earnings over the five-month period.

Leader gender and race

The gender and race of the senior executive were manipulated using headshot photos of professionals dressed in business attire. Each photo was paired with a neutral sounding name. To ensure that the photographs of the executives differed in terms of race but were similar on other physical dimensions, a pre-test was conducted. Twenty-nine participants from the same sample population as the participant pool evaluated 20 photographs of faces (5 Black women, 5 Black men, 5 White women and 5 White men) on race to confirm that the within race categories were perceived to be the same race (i.e., Black men to Black women) and that the between race categories were perceived to be of different races (i.e., White women to Black women). We asked the participants to specifically select the racial category of the person depicted in each of the headshots because racial characteristics can sometimes be ambiguous (Livingston & Brewer, 2002) and we wanted to make sure that the photos selected clearly depicted the racial category that we wanted to manipulate. In addition, participants evaluated the photos on age, physical attractiveness and emotional expression (to ensure comparability). Of the 20 photographs, four photos (one Black woman, one Black man, one White woman, and one White man) were selected because they were clearly recognizable as either Black or White and did not differ on perceived age, physical attractiveness or their emotional expression.

Perceptions of leadership effectiveness

Participants were asked to evaluate the executive on leader effectiveness (e.g., Manz & Sims, 1987). Leadership effectiveness was measured with four items: "I think that Jones is an effective leader," "I would have confidence in Jones's ability to be successful," "I would recommend Jones for other leader positions," and "An organization lead by Jones would be effective." The four items were measured on a 7-point Likert-type scale anchored by 1 (*strongly disagree*) and 7 (*strongly agree*). The composite items shared a univariate factor structure and inter-item consistency was high (*Cronbach's* $\alpha = .88$). Scores ranged from 1 to 7 ($M = 4.31$, $SD = 1.35$).

Perceptions of leader typicality

To assess leader typicality, participants were asked to evaluate the extent to which the executive is typical of a leader. We included only one trait word to assess leader typicality, given that the word "*typical*" clearly assesses typicality. This item was measured on a 7-point Likert-type scale anchored by 1 (*not at all*) and 7 (*extreme amount*). Scores ranged from 1 to 7 ($M = 4.31$, $SD = 1.26$).[2]

Results

Manipulation checks

Prior to assessing perceptions of the executive's leadership ability, participants' responded to a manipulation check to confirm the organizational performance manipulation. Responses confirmed that 98% of the participants correctly reported the organization's performance as described in the news article. At the end of the post questionnaire, two checks evaluated the manipulation of leader gender and leader race. These questions were placed near the end of the post-questionnaire so as not to bias the primary dependent variables. Approximately 94% of the participants correctly identified the leader's gender and 93% correctly identified the leader's race. Given the high response accuracy on the manipulation checks, we included all respondents in our final analysis. In addition, analyses removing manipulation check failures revealed the same outcomes.

Leader effectiveness

We conducted an analysis of variance (ANOVA) on leadership effectiveness with organizational performance, leader gender, and leader race as between-participant factors. Analysis revealed a main effect for performance, $F(1,220) = 194.67$, $p = .000$, $r = .68$. Leaders were perceived as more effective after organizational success ($M = 5.20$, $SD = 0.88$) than after organizational failure ($M = 3.41$, $SD = 1.13$). Analysis also revealed a main effect for leader gender, $F(1,220) = 13.44$, $p = .000$, $r = .24$. Men ($M = 4.52$, $SD = 1.35$) were perceived as more effective than women ($M = 4.11$, $SD = 1.33$). In addition, the analysis also showed a main effect for race, $F(1,220) = 5.77$, $p = .017$, $r = .16$, such that Whites ($M = 4.44$, $SD = 1.36$) were perceived as more effective than Blacks ($M = 4.17$, $SD = 1.33$). These main effects were qualified by a three-way interaction, $F(1,220) = 5.02$, $p = .026$, $r = .15$. The three-way interaction is presented in Fig. 1. The first set of bars contains mean leadership effectiveness ratings following organizational success, and the second set contains ratings after organizational failure.

To localize the effects of the three-way interaction, we conducted two-way interactions within each performance condition which showed that within the success condition, only a main effect for race, $F(1,220) = 4.22$, $p = .04$, and a main effect for gender, $F(1,220) = 14.51$, $p = .0002$, were significant. The two-way interaction between leader gender and leader race did not obtain significance, $F(1,220) = 1.38$, $p = .24$. As expected, simple effects analysis revealed that Black women did not differ from Black men, $F(1,220) = 1.98$, $p = .161$, or White women, $F(1,220) = 0.14$, $p = .705$. In addition, White men were perceived as more effective than Black men, $F(1,220) = 3.92$, $p = .049$, and White women, $F(1,220) = 9.17$, $p = .003$.

In the failure condition, the gender main effect was significant, $F(1,220) = 4.16$, $p = .043$; however, this main effect was qualified by a significant two-way interaction, $F(1,220) = 3.97$, $p = .048$. Black women were evaluated as less effective than both Black men, $F(1,220) = 7.99$, $p = .005$, and White women, $F(1,220) = 6.81$, $p = .01$.

Leader typicality

We conducted an ANOVA on leader typicality with the same between-participant factors that were used for leader effectiveness. Analysis revealed a main effect for organizational performance,

[2] Three participants did not respond to this question.

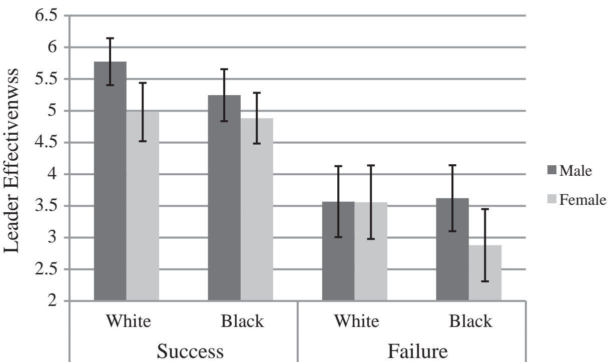


Fig. 1. Mean ratings and standard deviations for leader effectiveness as a function of organizational performance, leader gender, and leader race.

$F(1,217)=24.74$, $p=.000$, $r=.32$, whereby leaders were perceived to be more typical after organizational success ($M=4.68$, $SD=1.22$) than after organizational failure ($M=3.95$, $SD=1.21$). Thus, organizational success was perceived to be more consistent with leader typicality than was organizational failure. Analysis also revealed a main effect for gender, $F(1,217)=5.79$, $p=.000$, $r=.24$. Women ($M=4.05$, $SD=1.28$) were perceived to be less typical leaders than men ($M=4.59$, $SD=1.19$, $p=.001$). The race main effect was only marginally significant, $F(1,217)=3.16$, $p=.07$, $r=.12$, whereby Blacks ($M=4.18$, $SD=1.20$) were perceived as slightly less typical than Whites ($M=4.43$, $SD=1.31$). In addition, the two-way interaction between success and leader gender was marginally significant, $F(1,217)=3.45$, $p=.07$, $r=.12$. These main effects and interaction were qualified by a significant three-way interaction, $F(1,217)=4.76$, $p=.03$, $r=.17$. The three-way interaction is depicted in Fig. 2.

To localize the source of the three-way interaction, we calculated two-way interactions within the two performance conditions. Within the success condition, the race main effect, $F(1,217)=3.853$, $p=.05$, was significant indicating that Blacks were perceived as less typical than Whites. In addition, the gender main effect was significant indicating that women were perceived as less typical than men, $F(1,217)=15.55$, $p=.0001$. The two-way interaction between race and gender was not significant, $F(1,217)=0.67$, $p=.41$. However, White men were perceived as more typical leaders than White women, $F(1,217)=11.23$, $p=.001$, and marginally more typical than Black men, $F(1,217)=3.65$, $p=.058$.

Within the failure condition, there were no significant main effects; however, the two-way interaction was significant, $F(1,217)=5.12$, $p=.025$. Black women were perceived as less typical than both Black men, $F(1,217)=6.20$, $p=.014$, and White women, $F(1,217)=3.97$, $p=.048$.

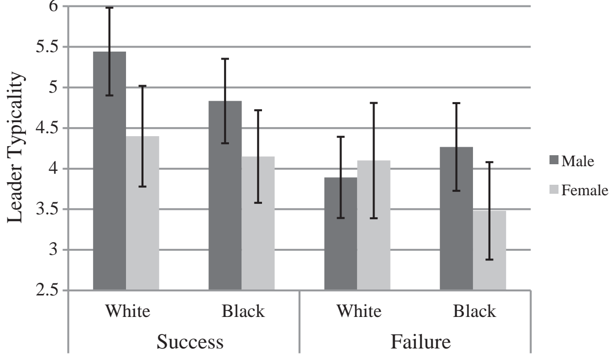


Fig. 2. Mean ratings and standard deviations for leader typicality as a function of organizational performance, leader gender, and leader race.

Mediation testing

To test whether leader typicality mediated the relationship between leader gender, leader race, and leader effectiveness as predicted, we tested the overall significance of the indirect effect (i.e., the path through the mediator) by using bootstrapping to construct bias-corrected 95% confidence intervals (Hayes, 2009; Preacher & Hayes, 2004; Stine, 1989). If zero falls outside the confidence interval, the indirect effect is deemed significant and mediation can be said to be present. Our model included leader race and organizational performance as two moderators of the path from leader gender to leader typicality (i.e., organizational performance moderated leader race and leader race moderated the path from leader gender to typicality). Hence, we tested mediated moderation which assessed the indirect effect of leader gender, leader race, and organizational performance on leader effectiveness through leader typicality. The indirect effect of leader gender on leader effectiveness, mediated through typicality for White leaders with successful organizational performance [CI: −1.11, −.31], Black leaders with successful organizational performance [CI: −.83, −.08], and most importantly, Black leaders with poor organizational performance [CI: −.93, −.09]. Specifically, leader typicality mediated the relationship between Black men and Black women when organizational performance was poor. Typicality did not mediate the relationship for Whites with poor organizational performance [CI: −.32, .52]; however, this was expected given that White men did not differ significantly from White women on leader effectiveness in the failure condition, $F(1,220)=.01$, $p=.97$.

Discussion

We examined the conditions under which double jeopardy would be experienced by Black women in leader roles, informed largely by research on recognition-based and inference-based processes of leadership. Our results indicate that double jeopardy was more likely to occur under conditions of organizational failure as opposed to success because their two subordinate identities were better matched to subpar as opposed to successful outcomes. Stated differently, White women and Black men benefited from at least one predominant identity that is congruent with the leader role (i.e., being White or male) and therefore were not evaluated as harshly as Black women whose race and gender aligned succinctly with failure.

However, when Black women leaders were successful, their two subordinate identities did not result in double jeopardy as Black women were evaluated comparably to leaders with single-subordinate identities—White women and Black men. The fact that Black women were evaluated comparably to White women and Black men in the context of success underscores the idea that there was not a clear alignment between recognition-processes and inference processes for these three groups and thus, they were evaluated comparably to each other. This idea is further bolstered by the fact that White men were shown to benefit separately from their race and their gender (i.e., an additive effect) resulting in more favorable evaluations than Black men and White women during organizational success. In addition, leader typicality mediated the indirect effect of race, gender, and organizational performance on leader effectiveness which suggests that recognition processes can partially account for the negative evaluations of Black women leaders when organizational performance was low and for the positive evaluations of White male leaders when performance was high. Our findings add to existing research that examines both recognition and inference based processes in tandem (i.e., Carton & Rosette, 2011; Rosette et al., 2008) by examining how leadership perceptions differ for groups with single- versus dual-subordinate identities (a comparison that has been frequently overlooked in previous leadership research) when performance outcomes are considered.

Our research also contributes to the burgeoning literature that examines the advantages and disadvantages that accrue to individuals with multiple subordinate identities (Durik et al., 2006; Livingston

et al., 2012; Purdie-Vaughns & Eibach, 2008; Richardson & Loubier, 2008; Sanchez-Hucles & Davis, 2010; Settles, 2006). On the one hand, proponents for subordinate intersectionality (i.e., multiple subordinate identities) argue that individuals with single-subordinate identities are the most oppressed as they represent the archetype of their social group (Livingston et al., 2012; Remedios, Chasteen, Rule, & Plaks, 2011). On the other hand, advocates of a double or even triple jeopardy paradigm contend that individuals with multiple subordinate identities fair far worse than their single-subordinate brethren (e.g., Bowleg, 2008). Our results contribute to this debate by suggesting that it is important to consider the context under which multiple identities are examined. For example, Black women leaders may be permitted to show greater agency than White women leaders and Black male leaders without penalty (Livingston et al., 2012). However, they may not be permitted to err as frequently without reprimand.

In addition to contributing to research on leadership and diversity, our findings have practical implications too. Black women executives may have to work exceptionally hard to minimize mistakes made on the job as their penalty for doing so may be greater than consequences experienced by White women and Black men. Given that atypical leaders, in general, are often expected to fail and are frequently evaluated more negatively when they make mistakes (Brescoll, Dawson, & Uhlmann, 2010), Black women may have to be exceptionally diligent when managing subpar outcomes. That is, they should take special care when organizational goals are not met (perhaps due to conditions beyond their control) to clearly communicate the circumstances to management, their peers, and even their subordinates. For their part, managers should be aware that such unfavorable bias may persist and take measures to make sure that leaders possessing more than one subordinate identity are evaluated fairly when goals are not achieved. Future research should examine how leaders who possess other subordinate identities (e.g., class, age, sexuality) are evaluated in a leadership context. In addition, future research should also examine contextual factors other than performance that may influence whether double jeopardy or intersectional invisibility is experienced by individuals who possess more than one subordinate identity.

Conclusion

Research on Black women leaders has received scant attention by leadership scholars in the past. Perhaps this oversight has occurred because of the negligible representation of Black women leaders in top positions. For example, in July 2009, Ursula Burns became the first Black woman leader of a Fortune 500 company. If we are to rectify the underrepresentation of Black women and others with more than one subordinate identity in top positions, it is important to understand the processes that disproportionately disadvantage them.

References

Almquist, E. M. (1975). Untangling the effects of race and sex: The disadvantaged status of Black women. *Social Science Quarterly*, *56*, 129–142.

Beale, F. (1970). Double jeopardy: To be Black and female. In T. C. Bambara (Ed.), *The Black woman: An anthology* (pp. 90–100). New York: Signet.

Beatty, R. W. (1973). Blacks as supervisors: A study of training, job performance, and employers' expectations. *The Academy of Management Journal*, *16*, 196–206.

Bell, E., & Nkomo, S. (2001). *Our separate ways: Black and White women and the struggles for professional identity.* Boston, MA: Harvard Business School Press.

Blake, S. (1999). At the crossroads of race and gender: Lessons from mentoring experiences of professional Black women. In A. J. Murrell, F. J. Crosby, & R. J. Ely (Eds.), *Mentoring dilemmas: Developmental relationships within multicultural organizations* (pp. 83–104). Mahwah, NJ: Erlbaum.

Bowleg, L. (2008). When Black + lesbian + woman (does not equal) Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*, *59*, 312–325.

Brenner, O. C., Tomkiewicz, J., & Schein, V. E. (1989). The relationship between sex role stereotypes and requisite management characteristics revisited. *The Academy of Management Journal*, *32*, 662–669.

Brescoll, V. L., Dawson, E., & Uhlmann, E. L. (2010). Hard won and easily lost: The fragile status of leaders in gender-stereotype-incongruent occupations. *Psychological Science*, *21*, 1640–1642.

Carton, A., & Rosette, A. S. (2011). Explaining bias against black leaders: Integrating theory on information processing and goal-based stereotyping. *Academy of Management Journal*, *54*, 6.

Chung-Herrera, B., & Lankau, M. (2005). Are we there yet? An assesssment of fit between stereotypes of minority managers and the successful-manager prototype. *Journal of Applied Social Psychology*, *35*(10), 2029–2056.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 139–167.

Durik, A. M., Hyde, J. S., Marks, A. C., Roy, A. L., Anaya, D., & Schulz, G. (2006). Ethnicity and gender stereotypes in emotion. *Sex Roles*, *54*, 429–445.

Eagly, A., Johannesen-Schmidt, M. C., & van Engen, M. L. (2003). Transformational, transactional, and laissez-faire leadership styles: A meta-analysis comparing women and men. *Psychological Bulletin*, *129*, 569–591.

Eagly, A., & Karau, S. (1991). Gender and the emergence of leaders: A meta-analysis. *Journal of Personality and Social Psychology*, *60*(5), 685–710.

Eagly, A., & Karau, S. (2002). Role congruity theory of prejudice toward female leaders. *Psychological Review*, *109*(3), 573–598.

Epstein, C. F. (1973). Black and female: The double whammy. *Psychology Today*, *89*. (pp. 57–61).

Ford, J., Kraiger, K., & Schechtman, S. (1986). Study of race effects in objective indices and subjective evaluations of performance: A meta-analysis of performance criteria. *Psychological Bulletin*, *99*, 330–337.

Foti, R., Fraser, S., & Lord, R. (1982). Effects of leadership labels and prototypes on perception of political leaders. *The Journal of Applied Psychology*, *67*(3), 326–333.

Foti, R., & Lord, R. (1987). Prototypes and scripts: The effects of alternative methods of processing information on rating accuracy. *Organizational Behavior and Human Decision Processes*, *39*, 318–340.

Greenhaus, J., Parasuraman, S., & Wormley, W. (1990). Effects of race on organizational experiences, job performance. *The Academy of Management Journal*, *33*(1), 64–87.

Hall, E. V., Phillips, K. W., Rudman, L. A., Glick, P., Livingston, R. W., Rosette, A. S., and Washington, E. F. (2012). Unpublished data. Northwestern University.

Hayes, A. F. (2009). Beyond Baron and Kenny: Statistical mediation analysis in the new millennium. *Communication Monographs*, *76*, 408–420.

Heilman, M. E., Block, C., Martell, R., & Simon, M. (1989). Has anything changed? Current characterizations of men, women, and managers. *The Journal of Applied Psychology*, *74*(6), 935–942.

Knight, J. L., Hebl, M. R., Foster, J. B., & Mannix, L. M. (2003). Out of role? Out of luck: The influence of race and leadership status on performance appraisals. *Journal of Leadership and Organizational Studies*, *9*(3), 85–93.

Kunda, Z., & Spencer, S. (2003). When do stereotypes come to mind and when do they color judgment? A goal-based theoretical framework for stereotype activation and application. *Psychological Review*, *129*(4), 522–544.

Livingston, R. W., & Brewer, M. B. (2002). What are we really priming? Cue-based versus category-based processing of facial stimuli. *Journal of Personality and Social Psychology*, *82*, 5–18.

Livingston, R. W., Rosette, A. S., & Washington, E. F. (2012). Can an agentic Black woman get ahead? The impact of race and agentic emotional expression on female leader status. *Psychological Science*, *23*(4), 354–358.

Lord, R., DeVader, C. L., & Alliger, G. M. (1986). A meta-analysis of the relation between personality traits and leadership perceptions: An application of validity generalization procedures. *The Journal of Applied Psychology*, *71*, 402–410.

Lord, R., Foti, R., & DeVader, C. (1984). A test of leadership categorization theory: Internal structure, information processing, and leadership perception. *Organizational Behavior and Human Performance*, *34*, 343–378.

Lord, R., & Maher, K. (1991). *Leadership and information processing.* Boston: Unwin Hyman.

Manz, C. C., & Sims, H. P. (1987). Leading workers to lead themselves: The external leadership of self-managing work teams. *Administrative Science Quarterly*, *32*, 106–129.

Meindl, J. R., & Ehrlich, S. B. (1987). The romance of leadership and the evaluation of organizational performance. *The Academy of Management Journal*, *30*, 91–109.

Meindl, J. R., Ehrlich, S. B., & Dukerich, J. M. (1985). The romance of leadership. *Administrative Science Quarterly*, *30*, 78–102.

Nye, J., & Forsyth, D. (1991). The effects of prototype-based biases on leadership appraisals: A test of leadership categorization theory. *Small Group Research*, *22*, 360–379.

Parker, P. S., & ogilvie, d. t. (1996). Gender, culture, and leadership: Toward a culturally distinct model of African-American women executives' leadership strategies. *The Leadership Quarterly*, *7*, 189–214.

Phillips, J. (1984). The accuracy of leadership ratings: A cognitive categorization perspective. *Organizational Behavior and Human Performance*, *33*, 125–138.

Powell, G., & Butterfield, A. (1997). Effect of race on promotions to top management in a federal department. *The Academy of Management Journal*, *40*(1), 112–128.

Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS procedures for estimating indirect effects in simple mediation models. *Behavior Research Methods, Instruments, & Computers*, *36*, 717–731.

Purdie-Vaughns, V., & Eibach, R. P. (2008). Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex Roles*, *59*, 377–391.

Remedios, J. D., Chasteen, A. L., Rule, N. O., & Plaks, J. E. (2011). Impressions at the intersection of ambiguous and obvious social categories: Does gay + Black = likable? *Journal of Experimental Social Psychology*, *47*, 1312–1315.

Richardson, A., & Loubier, C. (2008). Intersectionality and leadership. *International Journal of Leadership Studies*, *3*(2), 142–161.

Rosette, A. S., Leonardelli, G., & Phillips, K. W. (2008). The white standard: Racial bias in leader categorization. *The Journal of Applied Psychology*, *93*(4), 758–777.

Rush, M. C., Phillips, J. S., & Lord, R. G. (1981). Effects of a temporal delay in rating on leader behavior descriptions: A laboratory investigation. *The Journal of Applied Psychology*, *66*, 442–450.

Sanchez-Hucles, J. V., & Davis, D. D. (2010). Women and women of color in leadership: Complexity, identity, and intersectionality. *The American Psychologist*, *65*(3), 171–181.

Schein, V. E. (1973). The relationship between sex role stereotypes and requisite management characteristics. *The Journal of Applied Psychology*, *57*, 95–100.

Schein, V. E. (2001). A global look at psychological barriers to women's progress in management. *Journal of Social Issues*, *57*(4), 675–688.

Scott, K., & Brown, D. (2006). Female first, leader second? Gender bias in the encoding of leadership behavior. *Organizational Behavior and Human Decision Processes*, *101*, 230–242.

Settles, I. H. (2006). Use of an intersectional framework to understand Black women's racial and gender identities. *Sex Roles*, *54*, 589–601.

Shamir, B. (1992). Attribution of influence and charisma to the leader: The romance of leadership revisited. *Journal of Applied Social Psychology*, *22*, 386–407.

Stine, R. (1989). An introduction to bootstrap methods. *Sociological Methods & Research*, *18*, 243–291.

Willemsen, T. M. (2002). Gender typing of the successful manager — a stereotype reconsidered. *Sex Roles*, *46*(11/12), 385–391.