To the Editor

Although experiences of sexual harassment (SH) are common among physicians, dermatology is reported to have the highest rate of SH by patients across all specialties (Notaro et al., 2020). In two previous survey studies, rates of SH by patients were much higher for female dermatologists, including trainees (DeWane et al., 2020; Kane, 2018). We sought to further investigate the prevalence of SH from male patients (SHMP) among dermatologists and their potential implications for clinical practice.

We developed an anonymous, online survey to query dermatologists’ experiences with male patients specifically. Institutional review board approval was obtained prior to the distribution of the survey via a listserv of 1914 board-certified dermatologists made available by the American Academy of Dermatology. The survey was conducted in March 2020. Statistical analysis was performed with SPSS, version 26 (IBM Corporation) using the χ² or Student’s t-test as appropriate, with two-tailed significance defined as p < .05.

Sixty-eight board-certified dermatologists completed the survey. Most respondents were female (59%), practiced in the Northeast (41%), and worked in private practice settings (63%; Table 1). Twenty-four respondents (35%) reported being sexually harassed by a male patient. Dermatologists who were younger or female were more likely to report SHMP (p = .042 and p < .001, respectively; Table 2). Compared with dermatologists who did not experience SHMP, those who did experience SHMP were more likely to provide care to a smaller proportion of male patients (p = .027) and to report having a patient develop an erection during examination (p = .027). There were no significant differences in comfort providing care to male patients, frequency of male genital area assessment during total body skin examination (p = .619), or comfort performing genital examinations in male patients (p = .536) among dermatologists with and without SHMP.

Our results are consistent with previous reports establishing SH by patients as a common occurrence for dermatologists, especially among female physicians (DeWane et al., 2020). Even when incidents seem harmless, all physicians should feel empowered to report gestures that cross professional boundaries. Standardized reporting policies, communication to patients, and transfer of care in response to an SH incident involving a patient should be developed to ensure the issue is addressed while minimizing disruption to patient and provider. The use of chaperones for patients may be an effective preventative strategy for SH. However, chaperones may also increase health care costs and escalate patient anxiety and embarrassment (Norwick et al., 2018). Additional practice considerations are needed to ensure dermatologists are comfortable in clinical settings without compromising quality of patient care.

Historically, physicians are thought of as being in a position of power in clinical environments, yet the high prevalence of sexual harassment underscores that physicians can be wronged by patients. Further study is needed regarding strategies to enhance patient understanding that sexual harassment is inappropriate and to support dermatologists after experiencing SHMP.

The limitations of our study include the small sample size, risk of response bias, and a survey that is limited to questions about interactions with male patients. Our low response rate may be explained by the sensitive nature of this topic and desire not to disclose SHMP. This small, preliminary study should direct future investigations of the consequences of SH on provider clinical behaviors and effects on practice patterns.

Conflicts of Interest

Dr. John Zampella is a consultant for X4 Pharmaceuticals.

Funding

None.

Study Approval

The author(s) confirm that any aspect of the work covered in this manuscript that has involved human patients has been conducted with the ethical approval of all relevant bodies.
Table 1
Summary of dermatologist respondents and practice characteristics.

| Variable | Sexually harassed by male patient, n (%) | Not sexually harassed by male patient, n (%) | p-value |
|----------|----------------------------------------|---------------------------------------------|---------|
| Age, years | 49 (94.1) | 1 (2.0) | 0.001 |
| Sex | Female | 38 (80.0) | 21 (20.0) | 0.002 |
| Years in practice | 12.8 | 19.2 | 0.035 |
| Cosmetic services provided | 1 (4.6) | 3 (13.0) | 0.059 |
| Relationship maintained after erection | 16 (66.7) | 17 (38.6) | 0.027 |
| Comfort providing care to male patients | 24 (100.0) | 24 (100.0) | 0.009 |
| Male genital area examined during TBSE > 50% of times | 12 (50.0) | 19 (43.2) | 0.051 |
| Behaviors and beliefs | 0 (0.0) | 0 (0.0) | 0.001 |
| Specific communication training for male patients | 5 (11.4) | 9 (20.0) | 0.010 |
| Awareness of AAD educational resources for male patients | 8 (17.8) | 11 (25.0) | 0.008 |
| Provider gender as perceived barrier for dermatologic care for male patients | 10 (22.2) | 20 (45.5) | 0.003 |

SD, standard deviation.

Table 2
Sexual harassment associations with provider demographics, experiences, behaviors, and beliefs.

| Demographics and practice characteristics | Sexually harassed by male patient, n (%) | Not sexually harassed by male patient, n (%) | p-value |
|------------------------------------------|----------------------------------------|---------------------------------------------|---------|
| Age, years | 44 (91.6) | 22 (46.0) | < 0.001 |
| Sex | Female | 22 (91.6) | 18 (40.9) | < 0.001 |
| Years in practice | 12.8 | 19.2 | 0.068 |
| Cosmetic services provided | 1 (4.6) | 3 (13.0) | 0.103 |
| Solo practice | 9 (37.5) | 21 (47.7) | 0.454 |
| Male patients seen, % | 42.7 | 49.6 | 0.027 |
| Clinical experiences | | | |
| Erection occurrence during examination | 16 (66.7) | 17 (38.6) | 0.027 |
| Preference to leave room after erection vs. other strategy | 4 (25.0) | 0 (0.0) | 0.044 |
| Relationship maintained after erection | 16 (66.7) | 40 (90.9) | 0.019 |
| Comfort providing care to male patients | 24 (100.0) | 43 (100.0) | 0.536 |
| Comfort with male genital examination | 24 (100.0) | 42 (95.5) | 0.0619 |
| Male genital area examined during TBSE > 50% of times | 12 (50.0) | 19 (43.2) | 0.051 |
| Behaviors and beliefs | 0 (0.0) | 0 (0.0) | 0.001 |
| Specific communication training for male patients | 5 (11.4) | 9 (20.0) | 0.008 |
| Awareness of AAD educational resources for male patients | 8 (17.8) | 11 (25.0) | 0.003 |
| Provider gender as perceived barrier for dermatologic care for male patients | 10 (22.2) | 20 (45.5) | 0.003 |

AAD, American Academy of Dermatology; TBSE, Total Body Skin Examination.

Other options included normalize the situation, ignore the erection, or confront the patient.

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