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## Editorial

### Sexual harassment from patient to provider<sup>☆</sup>



According to the U.S. Equal Employment Opportunity Commission, sexual harassment in the workplace includes unwelcome sexual advances, requests for sexual favors, and hostile verbal or physical conduct that affects one's work performance or employment and/or creates an inappropriate, hostile work environment (U.S. Equal Employment Opportunity Commission, 2009). With the #MeToo movement, the profound consequences of sexual harassment on the mental and physical health of those affected are now widely recognized. The #MeToo movement has infiltrated into medicine and helped expose the strikingly high rates of sexual harassment in our profession. A recent survey demonstrated that 70% of physicians in an academic medical center reported some form of sexual harassment. Female physicians were significantly more likely than their male counterparts to experience harassment (Jenner et al., 2019).

Very few studies have examined the prevalence of sexual harassment of providers by patients, but preliminary work suggests it may be significant. In the aforementioned survey, one third of female physicians reported experiencing sexual harassment from patients (Northwest Women's Law Center, 2016). Other studies suggest that sexual harassment perpetrated by patients may be even more prevalent than that by colleagues. A 2018 Medscape study surveyed 6235 health care providers and found that 27% of physicians were sexually harassed by patients whereas only 7% were sexually harassed by clinicians, medical personnel, or administrators at their workplace (Kane, 2018). Dermatology had the dubious honor of being the specialty with the highest rate of sexual harassment; 46% of dermatology providers had experienced some form of sexual harassment by a patient within the past year (Kane, 2018).

Based on our personal experiences and observations, we hypothesized that sexual harassment by patients in dermatology practice affects female providers more than male providers and may be associated with burnout and termination of patient-provider working relationships. To further investigate these hypotheses, we conducted an informal, anonymous, electronic survey within the Dermatology Division at the University of Washington. Our survey had a high response rate (70%). Thirty-four current and former division members, including resident physicians, responded. Of these, 55.9% identified as female and 44.1% as male. Fifty-eight percent of respondents were attending physicians, 29.4% were residents, and 8.7% were advanced practice providers.

Sexual harassment from patient to provider was a common occurrence for all genders, with 67% reporting such an experience. Female providers experienced much more sexual harassment by patients, with 84% of female providers reporting some form of sexual harassment compared with 40% of male providers. Specific patient-perpetrated behaviors reported included comments on appearance (85%), questions about marital status (59%), jokes or stories of a sexual nature (35%), and being asked on a date (11%). Most female providers experienced multiple episodes of sexual harassment by patients, with 42% reporting 4 to 10 occurrences and 37% reporting 11 to 50 occurrences over their careers. Veterans Affairs outpatient clinics had the highest reported frequency of sexual harassment by patients, followed by outpatient academic clinics. Relatively few providers reported experiencing sexual harassment by patients in an inpatient setting.

Sexual harassment in the workplace negatively affects women's careers and precipitates changes in jobs and financial stress (McLaughlin et al., 2017). In our cohort, 21% of female providers responded experiencing feelings of burnout due to sexual harassment by patients, compared with 0% of male colleagues. Further demonstrating gender differences in career impact, 16% of female respondents had changed practice setting due to patient-perpetrated sexual harassment and 37% of female respondents had terminated a relationship with a patient based on unwanted sexual behavior. No male respondents had undertaken either action as a result of sexual harassment.

Some aspects of medical practice render all physicians, including dermatologists, susceptible to sexual harassment by patients, such as 1:1 contact behind closed doors, a perceived power differential between provider and patient, and the concept that medicine is to some degree a service industry with providers trained to put patients' needs first. However, we hypothesize that factors unique to dermatology make our providers particularly susceptible, including the degree of patient disrobing required for full skin examinations and physical contact with patients during the examination. In addition, the growing young, female workforce may be at particular risk for sexual harassment.

Addressing patient-to-provider sexual harassment is challenging, particularly when considering the complexities of maintaining the patient-physician relationship. Decreasing patient-to-provider sexual harassment should be a specialty-wide goal. First, several preventative strategies can be taken to lessen the risk of sexual harassment. These include having a chaperone in the room, such as a medical assistant or scribe, who may provide additional physical safety and buffer patient perceptions of the intimacy of a one-on-one examination setting. Additionally, ensuring that the provi-

<sup>☆</sup> No human subjects were included in this study. No animals were used in this study.

der is not present when patients disrobe, change into a gown, and then change back into their clothing is prudent.

Second, should sexual harassment occur, in-the-moment actions can be taken, either by the harassed provider or by a witness. We believe that it is critical that action be taken by the witness if the witness is a supervisor (eg, an attending) of the harassed provider (eg, student or resident physician). Addressing harassment by re-directing behavior with general phrases such as “let’s keep this professional” or “let’s keep this appointment focused on you” is simple and may help reset behavior. Next, naming the disruptive behavior and clearly directing the perpetrator can be impactful if behavior does not stop with redirecting (eg, “I want you to stop touching me; that is sexual harassment”). Additionally, physical safety is of paramount importance. It is always appropriate to remove oneself from any situation in which one feels physically unsafe. These small-scale, in-the-moment interventions can empower physicians and may discourage future sexual harassment by the patient.

Third, talking about and reporting sexual harassment from patients is important. Talking about an incident in the moment or debriefing it later can be a powerful way of bringing these incidents out from the shadows, reducing shame on the part of the harassed, and encouraging culture change. If a bystander witnesses an incident, acknowledging what they witnessed to the harassed can be normalizing and validating. Reporting to institutional offices, such as campus safety personnel, can be a mechanism to provide additional support and resources. Lastly, sexual harassment from patients may need to be documented in the medical record.

In sum, our survey suggests that sexual harassment is a common experience among female providers within our institution’s dermatology division. Sexual harassment may lead to burnout and career dissatisfaction, which, particularly for female providers, may serve as additional barriers to career advancement and retention. More research is needed to understand whether our observations are generalizable. To this end, we plan to survey a broader swath of medical providers across multiple disciplines and institutions with regard to their experiences.

## Conflicts of interest

Authors do not have any associations, current and over the past 5 years, that might pose a conflict of interest.

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None.

## Study Approval

NA.

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