SPECIAL ARTICLE

SEXUAL HARASSMENT OF FEMALE DOCTORS BY PATIENTS

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Abstract  Background. Sexual harassment within the doctor–patient relationship is typically discussed in terms of male doctors harassing female patients. We investigated the sexual harassment of female doctors by patients.

Methods. Surveys were mailed to a random sample of 599 of the 1064 licensed female family physicians in Ontario, Canada. Respondents were asked about their experiences of sexual harassment by either male or female patients and about the nature and frequency of harassing behavior. Suggestions for prevention were requested.

Results. Seventy percent (422) of the questionnaires were completed and returned. More than 75 percent of the respondents reported some sexual harassment by a patient at some time during their careers. Physicians had been harassed most often in their own offices and by their own patients. However, in settings such as emergency rooms and clinics, unknown patients presented a proportionately higher risk. The physicians' perceptions of the seriousness of the problem varied with the frequency and severity of the incidents.

Conclusions. Sexual harassment of female doctors appears to occur frequently, and it is therefore an important topic to address in medical school and professional development. (N Engl J Med 1993;329:1996-9.)

SEXUAL harassment in the workplace has been the focus of much media attention, litigation, and legislation. Substantial numbers of women (25 to 75 percent) in work settings ranging from the traditional (for example, nursing) to the nontraditional (for example, the automobile industry) are subjected to such harassment.1-5

Before 1976, sexual harassment was unnamed and undefined, although not unknown.6 Behavior that until recently was considered inevitable or just a part of life has now been defined as harassment in civil and human rights codes7 and in labor legislation in both the United States and Canada. In 1980 the Equal Employment Opportunity Commission (EEOC) defined sexual harassment as “unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.”8

Words and actions in and of themselves do not necessarily constitute harassment. The interpretation may depend on the context in which they occur and on the perception of a threat by the person to whom they are addressed. For example, the words “You are very attractive” may be taken as a compliment if they come from a close friend, or as the beginning of sexual harassment if they are spoken to a female job applicant by a male employer. In the United States, the criteria for sexual harassment include not only the effect of the remarks or behavior on the psychological well-being of the alleged victim, but also a “reasonable person’s” perceptions about the behavior in question. In 1991 a California court ruled that “the appropriate perspective for judging a hostile environment claim is that of the ‘reasonable woman,’” although the court also recognized that “a woman’s perspective may differ substantially from a man’s.”9

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That victims of sexual harassment are almost always women shows that this is a society in which women generally lack power relative to men. For that reason, the discussion of sexual harassment in the context of the doctor–patient relationship has generally focused on the harassment of female patients by male doctors.10,11 Almost by definition, physicians hold a position of power and trust, which is accentuated by the patient’s vulnerability. One might expect this imbalance in power to preclude the possibility that a patient would harass a physician sexually.

Female physicians share the power of their profession with their male counterparts, but they share with other women the vulnerability of their sex. Sexual harassment is not unfamiliar to female medical students and physicians.12,13 Indeed, in one study nearly 75 percent of female medical residents reported harassment — sometimes by patients, but primarily by male physicians.14 Because such a resident’s future career may depend on a positive evaluation from her supervisor, she, like an employee, is vulnerable to the supervisor’s power.

Once a woman graduates from medical school, however, does a medical degree confer on her the power inherent in being a physician, and if so, does that power protect her from sexual harassment by patients? Researchers have documented harassment of nurses by patients,5 but we know of no studies that quantify or describe the experience of female physicians. Anecdotal evidence in studies of other aspects of sexual abuse within the health care system suggests that sexual harassment by patients is not rare.10

In this study, female doctors were asked to quantify and describe any episodes in which they were harassed sexually by a patient. They were also invited to suggest ways of preventing such incidents and of training future physicians so that sexual harassment would be less likely.

Methods

In May 1992 a questionnaire was mailed to 599 female family physicians randomly selected from the 1064 female certificate holders of the Canadian College of Family Physicians who were in
active practice in Ontario, Canada's largest province (population, over 10 million). A cover letter explained the study and presented the EEOC definition of sexual harassment.

To maintain confidentiality, the questionnaires did not ask the respondents to identify themselves. Instead, respondents were asked to mail a card to a different address, on which they indicated whether they wished to discuss the topic of sexual harassment in a group. All those surveyed received a reminder postcard sent 10 days later. A second questionnaire was sent to those who did not respond within three weeks after the first mailing.

The questionnaire sought demographic information and details about the physician's practice, making clear that only incidents occurring in the course of the physician's work and involving patients (male or female) were germane to the study. The range of types of behavior studied was established by asking the respondents to recall the following: suggestive looks; sexual remarks; suggestive gestures; inappropriate gifts; pressure for dates; suggestive exposure of parts of the body; brushing, touching, or grabbing; grossly inappropriate touching (e.g., fondling a breast); and rape or attempted rape. The respondents indicated which types of behavior they had encountered at any time during their careers. In addition, they were asked to indicate the setting in which the harassment occurred (office, physician's home, the hospital, during a house call, or other) and the mode (in person, by mail, or by telephone). The frequency of harassment was determined by requesting estimates of how many times per year each type of behavior occurred.

Physicians who had encountered harassment were asked to describe one such incident in detail, indicating the sex of the harasser and their own response. All the respondents were asked to make suggestions about methods of prevention and to rate the seriousness of the problem on a five-point scale.

Data were analyzed with SPSS,PC+ software. A Pearson correlation coefficient was used to test relations between the proportion of male patients in a given practice and the frequency of harassment, as well as the range of incidents. Analysis of variance was used to test the relation between the respondents' ratings of sexual harassment as a problem and the incidence and variety of types of sexual harassment they experienced, the frequency of harassment, and the nature and location of the practice. All tests were two-tailed, where applicable.

RESULTS

Of the 599 physicians surveyed, 422 (70 percent) returned completed questionnaires. Five questionnaires were excluded from consideration because the respondents were not practicing as family physicians at the time of the study. The 417 eligible respondents represented 69.6 percent of the sample and 39 percent of all female certificate holders in family practice in Ontario.

Demographic Characteristics

The respondents ranged in age from 26 to 64 years, with 71 percent (298 women) under the age of 40. Eighty-two percent (340 women) had received their medical degrees after 1976 and thus had provided direct patient care for a maximum of 15 years. The majority worked in group practices (56 percent, or 234 women) and in urban areas (59 percent, or 246 women).

Half the women (49 percent, or 203 women) had been in their current practice for four years or less. A majority had worked either full-time (53 percent, or 223 women) or a mixture of full-time and part-time (27 percent, or 111 women) since receiving their medical degree.

Eighty-eight percent of the respondents said that less than 30 percent of their patients were men.

Harassment

More than three quarters of the women surveyed (77 percent, or 321 women) reported having been sexually harassed by a patient at least once during their career. Among these women, the number who reported encountering each type of harassment is shown in Table 1. The frequency with which each type of behavior occurred ranged from less than once a year to once a month or more, except for grossly inappropriate behavior, which ranged from less than once a year to three times per year. The frequency of harassment did not vary with the location of the doctor's practice (i.e., rural vs. urban). The average reported frequency of harassment was highest for doctors practicing in emergency rooms or at community health centers and for those serving as locums (working as temporary replacements for other physicians); it was lowest for those in group or solo practices (P = 0.07). Both the variety of incidents (P < 0.01) and the frequency of harassment (P < 0.01) were directly related to the proportion of male patients in the practice.

Two hundred seventy-nine respondents provided anecdotal examples of harassment. In the majority of these incidents (reported by 92 percent, or 257 women), the harasser was male. In most cases, the physicians had been harassed by their own patients (56 percent, or 156 women), although in the other cases the harassers were the patients of a colleague (11 percent, or 32 women), new patients (9 percent, or 26 women), or patients in emergency departments and walk-in clinics (14 percent, or 40 women). Sexual harassment occurred most commonly in the privacy of the office.

The respondents extensively described the behavior they defined as harassment. Among the common types of behavior thus reported were requests for genital examinations by patients who had no physical findings and displays of erections by patients before or during a physical examination.

The respondents indicated that they thought much abusive behavior resulted from the disassociation associated with drug and alcohol use. Physicians reported being grabbed, fondled, and having their breasts brushed by intoxicated patients, particularly in emergency departments. They also reported receiving inappropriate gifts from patients, including a bouquet of flowers accompanied by a sexually explicit letter.

Table 1. Types of Sexual Harassment Encountered by Respondents at Any Time during Their Careers.

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>NO. (%) OF Respondents</th>
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<tbody>
<tr>
<td>Suggestive looks</td>
<td>221 (53)</td>
</tr>
<tr>
<td>Sexual remarks</td>
<td>245 (59)</td>
</tr>
<tr>
<td>Suggestive gestures</td>
<td>118 (28)</td>
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<tr>
<td>Inappropriate gifts</td>
<td>91 (22)</td>
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<tr>
<td>Pressure for dates</td>
<td>96 (23)</td>
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<tr>
<td>Suggestive exposure of body parts</td>
<td>130 (31)</td>
</tr>
<tr>
<td>Brushing, touching, or grabbing</td>
<td>81 (19)</td>
</tr>
<tr>
<td>Grossly inappropriate touching</td>
<td>15 (4)</td>
</tr>
<tr>
<td>Rape, attempted rape</td>
<td>1 (&lt;1)</td>
</tr>
</tbody>
</table>
G-strings, a tape of love songs with a follow-up telephone call to the physician’s home to see how she liked the songs, and a deceased wife’s clothes.

Sixteen respondents described experiences that had a sexual content but did not classify them as harassment, either because the behavior seemed ambiguous or because the patient had a psychological or neurologic illness. Examples included a male patient with some tearing of his frenulum who masturbated in front of the physician to demonstrate his problem; a patient who wanted a sperm count and asked the doctor to help him obtain the sample because he said he found masturbating distasteful; a female patient who had an orgasm during an internal examination; and male patients who refused to be draped during physical examinations.

Responses to Harassment

The 279 physicians who described incidents of harassment reported having various responses — anger (in 35 percent, or 99 women), fear (in 26 percent, or 73 women), amusement (in 9 percent, or 26 women), and indifference (in 10 percent, or 27 women). Usually the physicians later told a female colleague about the event (53 percent, or 147 women). Only 15 incidents (5 percent) were reported to the police. Fifty-two women (19 percent) said that they had told no one.

Among the respondents who told one or more people about the incident, the majority felt greatly supported (74 percent, or 167 women) and “not at all” blamed after doing so (97 percent, or 222 women). Some of these same respondents wondered, however, whether they had been too friendly or familiar, had dressed provocatively or had been insensitive to the patients’ real needs in the confusion caused by their own discomfort and embarrassment.

More than half the physicians who reported being harassed by one of their own patients (101 of 156 women, or 65 percent) continued to provide care to that patient. Their reasons for doing so included a feeling that the incident had been dealt with adequately, a reluctance to judge the behavior of mentally ill or senile patients, and the perception that the physician could not refuse care to one member of a family without raising questions from other family members, particularly the wives of harassers. When care was discontinued, in 30 percent of the cases it was discontinued because the patient never returned, whereas in the remainder of instances the physician either asked or assisted the patient to find care elsewhere.

Despite the high proportion of physicians reporting sexual harassment by patients and the high proportion interested in discussing the problem further (53 percent of those who returned cards), less than one quarter of respondents (22 percent, or 79 women) rated the problem as serious (Table 2). The gravity of the problem was perceived in relation to the behavior encountered, with doctors who reported higher rates of harassment (P<0.001) and a wider range of incidents (P<0.001) judging the problem to be more serious.

Preventing Harassment

The suggestions for preventing harassment were numerous and varied. They addressed issues of personal behavior, office security, the need for safe and supportive workplaces, and the recognition of the social values underlying sexual harassment. Many respondents stressed the need to address the issue of sexual harassment and the particular vulnerability of women during medical training.

Discussion

The decision to study only female physicians was a considered one. In all settings, existing studies of harassment16 suggest that it is women or children who are most often victimized, usually by men, because they are seen as vulnerable. The extent of sexual harassment of male physicians remains to be documented, but that documentation would not alter the abuse women experience.

Our results suggest that sexual harassment of female physicians is widespread and troublesome. The physicians surveyed make up a substantial proportion of all women in active family practice in Ontario. The high response rate and the length of responses, as well as the participants’ interest in discussing the problem further in groups, suggest that even though only a minority considered the problem serious when questioned directly, sexual harassment is a disturbing and confusing matter.

It can be inferred from the results that certain work situations pose particular risks. Although respondents overall were more likely to be harassed by their own patients in their own offices, presumably this is where they spend most of their time. In contrast, those working as emergency physicians, locums, and in clinics, where there is a higher proportion of previously unknown patients, were harassed more often.

The reporting in this study may underestimate the actual extent of harassment. Harassment by coworkers or colleagues was specifically excluded. Behavior that some might describe as harassment was excused by others as inevitable or unremarkable. Moreover, women doctors belong to a society in which suffering sexual harassment is sufficiently common that it becomes part of being a woman, and is therefore ignored.

Although 77 percent of respondents reported har-
assent, only a minority considered it a serious problem for female physicians. Instead, the problem was often framed in personal terms. Either the doctor had been too familiar or had misinterpreted the behavior, or the patient was unwell or intoxicated and therefore excusably uninhibited. Confusion over responsibilities to patients and discomfort with the patients' behavior were viewed as personal shortcomings of the physician herself.

At a time when physicians are criticized for magnifying the inevitable differences in power that separate them from their patients, it is ironic that female doctors see the reinforcement of a physician's power as a means of protection. Despite this power, female doctors are treated primarily as women, not as physicians, by many of their male patients. The vulnerability inherent in their sex seems in many cases to override their power as doctors, leaving female physicians open to sexual harassment.

Female physicians take a number of steps to protect themselves. They may "hide" behind lab coats, gloves, and husbands' names, hoping to be shielded. They may pay for a variety of protective gadgets and services and hire office staff to be present at all times. Some may try to formalize the doctor–patient relationship by being cold, distant, controlling, and officious and by never speaking of themselves. To protect themselves with office structure and routine, physicians install alarm systems, avoid booking new patients at the end of the day when fewer coworkers are present, work with male physicians, give patients explicit instructions about draping, avoid performing male genital examinations without a nurse present, and leave the examining-room door ajar when uncertain about a patient.

If medical school faculty members recognized the problem and made available specific teaching sessions on the likelihood of harassment, its prevention, and the need for protection, the experience would be validated and depersonalized, and female doctors would be helped to overcome their vulnerability. The opportunity to view sexual harassment as an abuse of power, rather than an incident provoked by a victim's inappropriate dress or comments, may clarify the confusion felt by respondents over the causes of harassment and their responses to it.

A number of respondents commented that in answering the survey they had reconsidered their behavior and would feel better able to protect themselves in the future. Many expressed relief that a hidden and often frightening problem was being brought out into the open.

We are indebted to the women who replied to our questionnaire, to Francie Rutter for administrative support, to Susan Rickwood for editorial and research assistance, and to Darlene Newby for assistance in the preparation of the manuscript.

REFERENCES

7. The Ontario Human Rights Code, R.S.O., Ch. 19, S.72(1)90(Can.).