Table I. Physician performance with different delivery methods of the triage amalgamated dermoscopic algorithm used to teach dermoscopy

Category	Mean (%) score	Median (range) score	Sensitivity, %	Specificity, %
Live lecture, n = 59				
Before training	17.9 (60)	19 (5-26)	62.1	90.3
After training	23.5 (80)	23 (17-26)	88.0	87.8
P value	≤.001		≤.001	
E-learning, n = 43				
Before training	20.3 (68)	20 (12-27)	70.4	89.8
After training	24.7 (82)	25 (17-29)	91.5	87.6
P value	≤.001		≤.001	

an initial step for new users increasing their use of dermoscopy within our community and starting a journey toward broader use of this powerful tool in the clinical examination of patients.

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REFERENCES

1. Kittler H, Pehamberger H, Wolff K, Binder M. Diagnostic accuracy of dermoscopy. *Lancet Oncol*. 2002; 3(3):159-165.
2. Binder M, Schwarz M, Winkler A, et al. Epiluminescence microscopy. A useful tool for the diagnosis of pigmented skin lesions for formally trained dermatologists. *Arch Dermatol*. 1995;131(3):286-291.
3. Engasser HC, Warshaw EM. Dermatoscopy use by US dermatologists: a cross-sectional survey. *J Am Acad Dermatol*. 2010; 63(3):412-419, 419.e1-2.
4. Rogers T, Marino ML, Dusza SW, et al. A clinical aid for detecting skin cancer: the triage amalgamated dermoscopic algorithm (TADA). *J Am Board Fam Med*. 2016;29(6):694-701.
5. Rogers T, Marino M, Dusza SW, Bajaj S, Marchetti MA, Marghoob A. Triage amalgamated dermoscopic algorithm (TADA) for skin cancer screening. *Dermatol Pract Concept*. 2017;7(2):39-46.
6. Seiverling EV, Ahrns HT, Greene A, et al. Teaching benign skin lesions as a strategy to improve the triage amalgamated dermoscopic algorithm (TADA). *J Am Board Fam Med*. 2019;32(1):96-102.

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Sex trends in leadership of the American Academy of Dermatology: A cross-sectional study

To the Editor: Although women make up almost half of all dermatologists,[1] sex imbalances of women in leadership roles remain prominent.[2,3] In this study, we evaluated sex trends in the leadership of the American Academy of Dermatology (AAD) and compared our results with trends in new board-certified dermatologists.

Thirty-six years (1982-2018) of election data were obtained from the AAD, and 28 years (1990-2018) of board-certification data were obtained from the

American Board of Dermatology. The extracted data (including sex, position, and term duration) were tabulated, and periods of change were analyzed and aligned. The final analysis period was set as 1998-2018. Linear regression was used to model the direction of the data. Threshold significance was set to α level 0.05. Data analyses were performed by using Excel Data Analysis Toolpak (Microsoft, Redmond, WA).

Over the analysis period, a total of 12,013 AAD members were elected or appointed to leadership roles (president, vice president, board of directors, or committees). Twenty-six members without sex listed were excluded. Of the remaining members, 60.4% were male and 39.6% were female. Over the same period, 7844 individuals became board-certified dermatologists, of which 39.9% were male and 60.1% were female.

Both total number and percentage of women elected or appointed to leadership positions increased during the analysis period, from 3 (23%) in 1998 to 508 (48%) in 2018 (Fig 1). These increases correlated with an increase of female board-certified dermatologists, indicated by a Pearson coefficient of $r = 0.82$. Linear regression showed both increases were significantly correlated with time ($P < .001$). The proportion of female board-certified dermatologists was consistently higher than the proportion of women in AAD leadership, although the latter showed faster growth (slopes 0.0109 and 0.0076, respectively; Fig 1).

In addition to the increases in the number of women elected to leadership positions, there were also increases in the number of women candidates running for leadership positions (Fig 2). Despite these gains, the increase was not reflected in the proportion of women elected to presidential positions.

Our data shows that the total representation of women in leadership positions in the AAD has steadily increased since 1999. This growth is partially attributed to the increasing proportion of new female board-certified dermatologists. Although female involvement on the Board of Directors and in committees has increased, representation in the presidency and vice presidency is still lagging. There has never been a year in which women have held both presidential positions. These observations parallel the increasing presence of women as residency program directors (from 28% to 47.9%) yet underrepresentation as department chairs (from 16% to 23.5%).[4]

Women serving in leadership positions can help craft policies and serve as mentors, and they might be more likely to nominate other women for

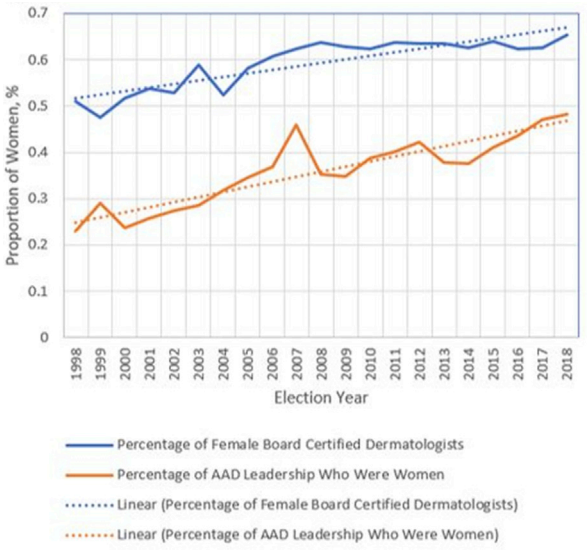

Fig 1. Proportion of women in leadership positions (President, Vice President, on the Board of Directors, or on a committee) of AAD versus newly board-certified women during 1999-2018. *AAD*, American Academy of Dermatology.

leadership roles.[5] There is a need for a task force to address barriers impeding women from pursuing leadership within dermatology.

Limitations of this study include the inability to analyze dermatologist workforce data. As executive positions are important in determining the direction of professional organizations, we hope that our data underscores the importance of continued progression toward a more balanced leadership distribution that reflects our current workforce.

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REFERENCES

1. 2018 Physician Specialty Data Report. Association of American Medical Colleges. https://www.aamc.org/data/workforce/reports/492536/2018-physician-specialty-data-report.html.
2. Sadeghpour M, Bernstein I, Ko C, Jacobe H. Role of sex in academic dermatology: results from a national survey. *Arch Dermatol.* 2012;148(7):809-814.

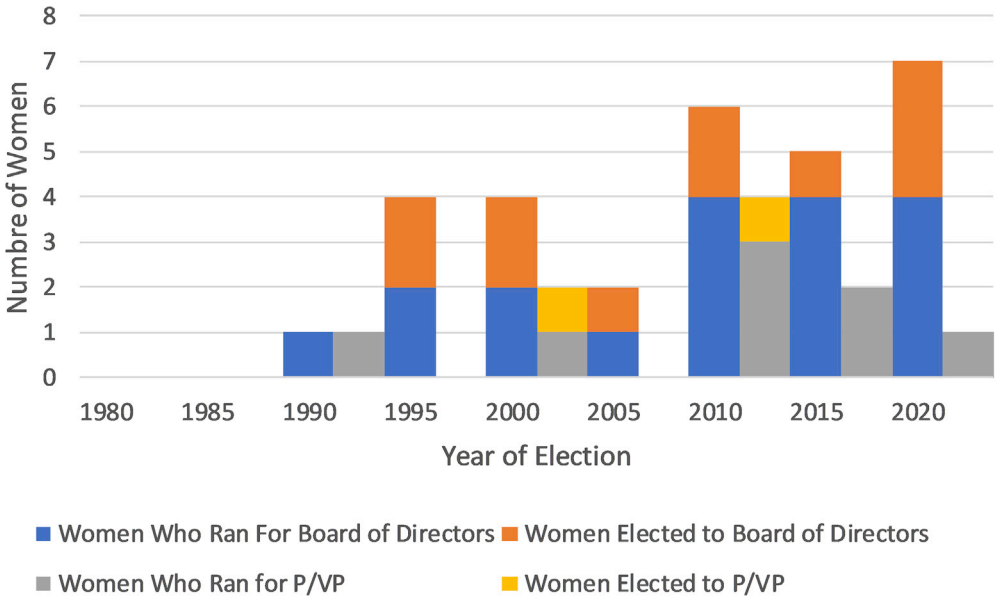

Fig 2. Women running for and elected to the leadership positions of P, VP, and Board of Directors of the American Academy of Dermatology during 1982-2020. *P*, President; *VP*, Vice President.

3. Wehner MR, Nead KT, Linos K, Linos E. Plenty of moustaches but not enough women: cross sectional study of medical leaders. *BMJ*. 2015;351:h6311.
4. Shi CR, Olbricht S, Vleugels RA, Nambudiri VE. Sex and leadership in academic dermatology: a nationwide survey. *J Am Acad Dermatol*. 2017;77(4):782-784.
5. Murrell DF, Ryan TJ, Bergfeld WF. Advancement of women in dermatology: advancement of women in dermatology. *Int J Dermatol*. 2011;50(5):593-600.

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A survey study of resident experiences of sexual harassment during dermatology training

To the Editor: Sexual harassment encompasses a wide range of verbal and nonverbal behaviors, including gender harassment, unwanted sexual attention, and sexual coercion.[1] Sexual harassment is a widespread problem in clinical medicine and academia and occurs across all specialties.[2,3] However, there is limited data on sexual harassment in dermatology specifically.

We developed an anonymous online survey addressing 16 harassment behaviors that was adapted from the previously validated National Academies of Sciences, Engineering, and Medicine and Administrator-Researcher Campus Climate Collaborative Campus Climate Survey.[1] Institutional review board approval was obtained before distributing the survey via the Association of Professors of Dermatology (APD) listserv (composed of 368 dermatology faculty and residency program coordinators). Listserv use was approved by the APD, and members were asked to forward the survey to their residents. All current US dermatology residents who received the survey were eligible to participate, and we accepted survey responses during August 3-24, 2018. The Qualtrics survey software, which prevents ballot box stuffing, was used to prevent multiple survey responses from any given resident. Descriptive statistics were performed in Excel (Microsoft, Redmond, WA). We determined 95% confidence intervals (CIs) for proportions using the Clopper-Pearson exact method for binomial proportions and the Sisonglaz method for multinomial proportions. Multivariable logistic regression was performed to evaluate the association between demographic variables and sexual harassment.

In total, 368 APD members received the survey link, and 106 residents completed the survey (Table I). Of 99 respondents, 55 (55%, 95% CI 44%-65%) felt that sexual harassment was definitely or probably a problem within dermatology residency programs, and 60 of 105 (57%, 95% CI 47%-67%) reported experiencing at least 1 of the survey behaviors. Controlling for race and age, the odds of experiencing sexual harassment were 3.5 times higher for women than men (adjusted odds ratio 3.5, 95% CI 1.4-8.8). Of 154 incidents reported in the survey, 99 incidents (64%, 95% CI 57%-72%) could be categorized as sexist hostility and gender harassment (defined as sexist behavior or comments, eg, saying that women don't belong in medicine), 40 incidents (26%, 95% CI 19%-34%) as sexual hostility and crude