A POIGNANT ABSENCE: SEXUAL HARASSMENT IN THE HEALTH CARE LITERATURE

In our work as health care practitioners, managers, and researchers, the topics that receive our attention and resources are shaped by the work of our predecessors. During formal education and in later career activities, the published literature serves as a reservoir of a discipline's important issues, including their conceptual and analytic treatments. However, the scientific professionalization process may restrict vision (Kuhn 1970). At the individual and organizational levels, response repertoires control what is noticed (Weick 1979). Thus, while the professional learning process generally provides beneficial continuity in the development and treatment of issues, the process may introduce subtle but significant attention filters.

This article reviews the treatment that sexual harassment among health care personnel receives in the health care literature. Several observations and reflective questions were
the impetus for the investigation, an example of the classic grounded theory approach of experiences and insights leading to further inquiry (Glaser and Strauss 1967). First, while the ratio of men to women in some health care professions has changed in recent years, medicine and administration still have a higher proportion of men, while nursing and support staff roles continue to be held mostly by women. The gender imbalance in health care roles is likely to continue in the foreseeable future. Gutek (1985) argues that sexual harassment is more likely to occur in settings where work roles are sex-linked and where the work groups' sex ratios are unbalanced. Therefore, health care would appear to be a likely setting for sexual harassment between superiors and subordinates, and among coworkers.

The second area of observation concerns nursing issues, specifically the seemingly intractable nature of the periodic shortage of nurses. The topic receives national attention when it reaches crisis proportions. During the various evaluations of the nursing shortage, to what degree has sexual harassment been investigated as a contributing factor to nursing practice concerns?

The final area of observation concerns the educational preparation of health care professionals. While sexual abuse of patients receives some discussion within the context of professional behaviors for clinicians, has the topic of sexual harassment among colleagues and subordinates been addressed in clinical and administrative training?

The issue of sexual harassment has important consequences for health care management and policy. First, health care services are labor intensive, making the individual staff person the most valuable component of the health care delivery. To the degree that the health care work environment is characterized by sexual harassment, the satisfaction, tenure, and productivity of individuals are compromised. Second, there is evidence that patient care outcomes are affected by professional relationships (Knaus et al. 1986). These points relate to the lives of both patients and professionals, and their consequences need to be at the forefront of health care management and policy decisions. Additionally, health care costs may increase due to the consequences of sexual harassment. Direct costs may be incurred by employers as a result of turnover and decreased productivity of harassed individuals. There may also be opportunity costs to the health care field from the loss of educated and skilled personnel if individuals leave health care practice due to sexual harassment.

This article begins with a definition of sexual harassment to establish a common frame of reference. Then the results of a conventional literature search and a qualitative analysis of articles in nine major health care journals over an 11-year time period are presented. Next, the national studies of nursing from 1970 through 1990 are reviewed for their treatment of the topic. Finally, a summary of this inquiry and recommendations for further investigations of sexual harassment in health care are offered.
SEXUAL HARASSMENT: A DEFINITION

In 1980 the Equal Employment Opportunity Commission (EEOC) provided the legal definition of sexual harassment:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting the individual; or such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment. (p. 74677)

As suggested by Rowe (1985), three aspects to the EEOC definition and guidelines should not be overlooked. First is the issue of effect and intent. Whether the person exhibiting a behavior did so only once and did so in jest, if damage occurred to the recipient of the behavior, (e.g., the withdrawal of a student from a university due to the incident), the effect was one of sexual harassment. Second, according to the EEOC guidelines, behavior that is verbal and happens only once may constitute sexual harassment. Third, consenting relationships may also result in a charge of sexual harassment in two ways: the first is when an individual wishes to terminate the relationship and the other individual tries to continue the relationship; the second is when a third person(s) believes the behavior of the two consenting individuals creates a problematic work environment.

The EEOC definition is considered to be a descriptive definition, but causal definitions have been proposed (Popovich and Licata 1987). Also, several efforts have been made to understand how people differ in their perceptions of sexual harassment based on gender (Gutek 1985) and other characteristics (Baker, Terpstra, and Larntz 1990).

ANALYSIS OF THE HEALTH CARE LITERATURE

The usual approach to a literature review is to consult the available indexes. Sexual harassment is not listed in the subject index of Index Medicus, nor does it appear as a key word entry using the computerized version of the index (National Library of Medicine 1991). Sexual harassment is not a subject in the Hospital Literature Index (American Hospital Association 1991). However, sexual harassment is a subject indexed in the Cumulative Index to Nursing and Allied Health Literatures (1991). The computerized CD-ROM version of the nursing and allied health literatures index had 43 articles on sexual harassment, discussed in the "Results" section.

Through the review of indexes, it is evident that if a subject is a minor point in an article it may not be indexed as a separate subject or key word. The absence of the topic of sexual harassment in the medical and hospital indexes, combined with the limited
treatment in the nursing literature, introduced the possibility of an indexing problem. Since indexes and computerized searches have such limitations, and given the limited number of articles on sexual harassment discovered through the literature indexes, another approach to discovering articles on sexual harassment among health care personnel was undertaken.

A labor-intensive review of selected journals was conducted, and Figure 1 displays the nine journals reviewed, frequency of publication, and current circulation for each. The journals selected were representative of several different audiences: physicians, nurses, administrators, and researchers. The Journal of the American Medical Association (JAMA), the American Journal of Nursing (AJN), and Hospital & Health Services Administration are the journals published respectively by the professional associations for medicine (American Medical Association), nursing (American Nurses Association), and administration (Foundation of the American College of Healthcare Executives). Medical Care is the publication of the medical care section of the American Public Health Association. The remaining journals were believed to be the most likely to address issues related to roles and relationships in health care delivery settings from research or practice perspectives, or both. According to Boissoneau and Schwahn (1989), Inquiry has a research emphasis and Health Care Management Review is a generalist management journal.

Each issue of the nine journals was reviewed for the years 1980 through 1990. Since the concept of sexual harassment was first developed in the late 1970s (Gutke 1985), the year 1980 was selected to allow time for the health care field to begin addressing the issue after its introduction in the popular press and organizational literature. The year 1990 was selected since, at the time of the study, it was the last complete year for which the journals were available. The span of 11 years provides a broad window to identify trends over what has been called a turbulent era in health care (Shortell and Zajac 1990).

From the review of indexes, it was apparent that sexual harassment would not be part of articles' titles. Hence, the scanning of the journals' tables of contents was expanded in several ways. First, attention was paid to titles addressing gender relationships among health personnel. Second, nursing recruitment and retention were important issues during this time period. Therefore, articles that addressed reasons for the nursing shortage, nursing satisfaction, nursing turnover, and physician-nurse collaboration were also reviewed. Finally, articles addressing organizational climate, women in medicine, and abuses of students were reviewed. While attention was not systematically focused on editorials and letters, several were noted and included in the analysis.

This journal review may be classified as a comparative study of a qualitative nature (Glaser and Strauss 1967). All reviews were conducted by the author over a one-month period. Having the reviews conducted by one individual eliminated interrater bias in consistent attention to terms. The time-consuming and labor-intensive nature of such a
review process, conducted over many review periods, introduces the possibility of systematic bias in the sole reviewer's attention in the direction of underreporting.

RESULTS

As expected from the review of indexes, no articles having "sexual harassment" in their titles were found in the nine journals during the 11 years. Figure 2 displays the distribution of the 94 articles identified from the qualitative review of journals for each of the three professional literatures on the topics of sexual harassment, gender, collaboration, nursing issues, and miscellaneous topics. (The specific references that were used to develop this summary are available from the author.)

Once made sensitive to the issue of sexual harassment, one is struck by its absence from the 90 articles on topics that might have been enriched by consideration of the dynamics of sexual harassment. For example, the gender-related articles included the subjects of sex-role identity (Meleis and Dagenais 1981; Till 1980), discrimination in salary and advancement (Caplan, LeRoy, Rosenthal, and Shyavit 1988), and sex-role stereotyping (Dempsey-Polan 1988; Groff 1984; Reverby 1987), without mention of sexual harassment. One article, an update from an earlier discussion (Stein 1967), characterized the doctor-nurse relationship as a "game" (Stein, Watts and Howell 1990). The most recent article elicited six letters, reported in the July 19, 1990 issue of the New England Journal of Medicine. Neither the articles nor the letters addressed sexual harassment as a component of the relationship problems between doctors and nurses.

The absence of the topic of sexual harassment from the 46 articles that addressed the issues of nursing recruitment, retention, satisfaction, and turnover should be a cause for astonishment. In particular, the absence of any measures related to the concept of sexual harassment in investigations of these nursing issues based on surveys of nurses (e.g., Clark 1980; McCrane, Lambert and Lambert 1987; Mueller and McCloskey 1990; Mottaz 1988; Pincus 1986; Seybolt 1986) raises the question of whether an attention filter exists in health care that generally precludes consideration of sexual harassment as a contributing factor to employment conditions. The question of an attention filter is also raised by articles that describe behaviors that would be classified as sexual harassment under the EEOC's guidelines (e.g., Fagin and Diers 1983; Kalisch and Kalisch 1983), yet the term is never applied by the authors.

As noted in Figure 2, sexual harassment among health care personnel was addressed in only 4 of the 94 articles (three from the medical field and one from the nursing field). No articles on sexual harassment were found in the health care research or administrative literature.

SEXUAL HARASSMENT IN THE MEDICAL LITERATURE

The three articles from the medical field appeared in a 1990 JAMA issue (Kay 1990;
Sheehan, Sheehan, White, et al. 1990; Silver and Glickman 1990). Each addressed sexual harassment in the context of abuses of medical students, presumably leading to indexing of the articles in the medical literature under headings related to medical education. The three articles were the most recent discussions in a series of explorations of the abuses experienced by medical students. Evolution of the conceptual and methodological treatment of medical student abuse, including sexual harassment, is worth reviewing in its entirety.

The JAMA discussion began in 1982, with a commentary by Silver in which he raised the possibility of a parallel between abuse of medical students and child abuse. Sexual harassment was not specifically mentioned. In 1984, Rosenberg and Silver noted that 37 of 38 physicians who sent unsolicited letters to JAMA after reading the 1982 commentary considered aspects of their treatment while medical students to have been abusive, with a variety of results affecting their learning, self-esteem, and career selection, as well as care they provided to patients. Rosenberg and Silver (1984) also presented examples of abuse from 50 medical school students at one university who volunteered to participate in individual interviews. Finally, they reported on the responses to an unspecified number of letters sent to associate or assistant deans of medical students for their impressions of student abuses. Of the 18 responses received, 16 denied the occurrence of medical student abuse at their schools. While sexual harassment was never explicitly discussed, the authors concluded that the abuses experienced by medical students affect their subsequent relationships with peers, families, and patients, and they identified the need for a minimum standard of conduct applicable to everyone in medical school.

The January 26, 1990, issue of JAMA contained the three articles that identified sexual harassment as one component of medical student abuse. Kay (1990) provided an overview of the problem of "deidealization" in an editorial. Sheehan, Sheehan, White, et al. (1990) presented results from a survey of third-year medical school students on their perceptions of mistreatment and professional misconduct. The American Medical Association's Office of Education Research participated in the design of the questionnaire. The questionnaire was administered at a special meeting in the Fall of 1988. A response rate of 81 percent was obtained (75 responses from a class of 93). From a list of abuses, students were asked to rate how often the abuse occurred using a 0 to 4 scale ranging from "never" to "frequently," and to list the source of abuse. The categories used for sexual harassment were "slurs," "advances," "denied opportunities," "malicious rumors," and "other sexual discrimination." The survey appeared to address the constructs of sexual harassment and discrimination based on sex (denied opportunities and other sexual discrimination). Only the responses of women to these questions were reported and it was not clear whether only women were asked these questions or whether there were no responses from men to these questions. Responses from all the students were reported for a question on types of behavior they had observed that they considered to be unethical or unprofessional. Sexual misconduct was one of the categories. Table 1 contains a summary of the findings related to sexual
Harassment and sexual misconduct.

Silver and Glicken (1990) investigated the incidences, severity, and significance of abuse as perceived by the medical students at one major medical school. Their operational definition of abuse follows:

To abuse is to treat in a harmful, injurious or offensive way; to attack in words; to speak insultingly, harshly and unjustly to or about a person; to revile. Abuse was further defined to refer particularly to unnecessary or avoidable acts or words of a negative nature inflicted by one person on another person or persons. (p. 527)

The authors noted that the definition was intentionally nonspecific to avoid imposing preconceived categories, allowing construction of a typology to emerge from the students' responses. One question asked the students to describe their most significant episodes of abuse. From content analysis to this open-ended question, five categories of abuse were determined: verbal abuse, institutional/academic/education system abuse, sexual abuse, physical abuse, and intentional neglect or lack of communication. The types of episodes categorized under sexual abuse included solicitation, harassment, physical advances, sexist remarks, and discrimination. While the design of this question precluded a quantitative analysis, the authors found that verbal abuse and institutional abuse occurred most frequently.

Sheehan, Sheehan, White, et al. (1990) cited an article in the Journal of the American Medical Women's Association (JAMWA). Entitled "Stress in the Role Constellation of Female Resident Physicians," Coombs and Hovanessian (1988) investigated role strain among 22 female residents at four medical centers representing a variety of specialty training programs. The contents of taped interviews were analyzed for themes. While the authors did not report quantitative results, the themes and quotations addressed many facets of roles and relationships among health care personnel, along with explicit examples of sexual harassment, including

1. The frequency with which a woman resident's gender was part of conversations and the frequency of sexual advances from married mentors;

2. Disadvantaged role demands, that is, expectations for doing menial tasks and creating a "cheerful atmosphere" like "housewives" to support men doing "the important work" (p. 22);

3. Sexual harassment from male support staff, noted as being especially common at the county and Veterans Administration (now Veterans Affairs) hospitals; and

4. Problems related to "shared gender related tasks" with predominantly female nurses, stating that
female nurses, accustomed to taking orders from male physicians, expect only a modicum of interpersonal civility, women physicians must be pleasant and helpful as well ... rather than submit to this unproductive and humiliating situation, some women residents distance themselves from nurses, playing the role like men. This can be hazardous, too, for nurses can either smooth the way or make things difficult. (p. 23)

This last quote highlights a possible situation in which behaviors among individuals of the same sex could be interpreted as sexual harassment under the EEOC's guidelines describing a hostile work environment. All of the articles on sexual harassment found in the medical literature addressed the problem in the context of individuals in training situations.

**SEXUAL HARASSMENT IN THE NURSING LITERATURE**

The one nursing article identified in Figure 2 is from a 1984 issue of the American Journal of Nursing (Moskowitz and Moskowitz 1984). The authors discussed sexual harassment as the last item in a list of employment-rights concerns. The article was indexed under the topic of sexual harassment in the nursing literature index. Finding only one article on sexual harassment among health care personnel while reviewing three important nursing journals—when 43 sexual harassment articles were listed in the nursing and allied health literatures index—has several explanations. First and most important, there has been scant attention to sexual harassment in the major nursing journals. One might wonder if these nursing journals were at least addressing sexual harassment with respect to nurse-patient relationships. Only one such article was found in the three nursing journals over the 11-year review period (Assey and Herbert 1983). However, six additional articles indexed in the nursing and allied health literatures under sexual harassment concerned patient-professional interactions, including harassing behaviors exhibited by patients and approaches for the professional to take in such situations (Hacker 1984; Heinrich 1987; Jordheim 1986), how to avoid situations in which the professional's behaviors may be interpretable as harassment (Knight 1989; Schunk and Parver 1989), and opportunities for health educators to address sexual harassment with clients and in working relationships (Riddle and Johnson 1983).

Many of the remaining articles indexed in the Cumulative Index to Nursing and Allied Health Literatures were not in publications widely available in the United States. Examples include state publications, and journals from Canada, Australia, and the United Kingdom, which have different legal statutes on sexual harassment. Some articles cited were more anecdotal in nature (Colonic 1984; Carlson 1988). One article appearing in the nursing literature reported the responses of 80 graduate psychology students to scenarios describing sexual harassment (Horgan and Reeder 1986), while another reported on a content analysis of case records from the Working Women's Institute in New York City (Crull and Cohen 1984). Bullough (1990) traced the history of sexual harassment in nursing, including Florence Nightingale's efforts to prevent sexual harassment through the selection, training, and separate living quarters...
for nurses, and the experiences of nurses in the American Civil War and in the first American schools of nursing.

Seven of the indexed nursing and allied health articles concerned the experiences of assistants in medical (Flight 1990) or dental offices (Reiter 1990; Waring and Horn 1987; Modaff 1985; Gervasi 1984a, 1984b; Snider 1984). Most of these articles were either overviews or anecdotes describing sexual harassment. However, Gervasi (1984a) reported on responses from 767 dental assistants to a questionnaire distributed in the journal published by the American Dental Assistants Association (ADAA). Forty-three percent of the respondents claimed they had experienced sexual harassment in dental settings. Ninety-seven percent of the women reporting incidents of sexual harassment claimed they eventually quit (79.8 percent) or were fired (17.2 percent) as a consequence of the harassment. The dentist-dental assistant roles, relationships, and employment situation may not be comparable to other health care delivery settings, where interactions among health care personnel may be more transient and less likely to be of an employer-employee nature. Further, this study relied on self-selection for participation. Nevertheless, the ADAA study obtained the largest sample size reported in the health care literature, and its design of structured and open-ended questions provides quantitative results and qualitative insights into the scope and effects of sexual harassment.

The majority of articles in the nursing literature may be classified as overview articles describing sexual harassment and its legal ramifications. Overview articles likely to be read by staff nurses have been published in RN (Arbeiter 1986a, 1986b; Horsley 1990) and The Registered Nurse (Carnerie 1989). Occasionally, overview articles appear in journals directed to staff nurses in particular specialties, such as occupational health nursing (Mendelson 1983) and operating room nursing (Julius and DiGiovanni 1990). Journals directed to nursing managers have presented the majority of introductory articles and are the ones most likely to discuss case law (Creighton 1987a, 1987b; Hory and Webb 1989; Goldberg and Reagan 1985; Regan 1989). While good sources of introductory information, these articles are not designed to offer further conceptual or methodological insights for investigating sexual harassment.

In summary, while there were more sexual harassment entries in the nursing and allied health literatures index, surprisingly few were substantive and applicable to the experiences of the majority of health care professionals in this country. Next, the articles investigating the extent of sexual harassment in nursing and those that offer behavioral, administrative, and therapeutic strategies for such situations are reviewed. The articles were identified from personal attention to the topic or through the Cumulative Index to Nursing and Allied Health Literatures.

The Extent of and Sources of Sexual Harassment, as Reported in the Nursing Literature
Only five studies on the characteristics and extent of sexual harassment in nursing were found in the literature. Two studies reported surveys of nursing students who volunteered to complete questionnaires on sexual harassment (Duldlt 1982; Cholewinski and Burge 1990). Neither of these studies, which used nonrandom samples, indicated the size of the population from which the nursing students volunteered. Duldlt (1982) reported the responses of 89 nurses who were attending a baccalaureate completion program on a part-time basis and who had experienced sexual harassment during the preceding year. The questionnaire included open-ended questions to elicit descriptions of sexual harassment incidents and structured questions on demographics, responses to the sexual harassment, and the effects of the experience. Cholewinski and Burge (1990) reported the source, type, and effects of sexual harassment for 21 students who had experienced harassment while enrolled in nursing programs. While the extent of sexual harassment among nursing students and in nursing cannot be determined from these studies, they provide insights into methods for studying the problem and pinpoint areas for further research. One result from Duldlt's survey is particularly disturbing and requires further investigation: rarely did the nurses report the incidents to their supervisors.

Griffin-Shelley (1985) reported the results of an employee survey at an inpatient psychiatric hospital. While the overall response rate to the survey was only 21.8 percent, the response rate for full-time female employees was 32.4 percent and 14.3 percent for full-time male staff. None of the men reported experiencing sexual harassment, but 47 percent of the women who responded reported some form of sexual harassment. For harasser characteristics, Griffin-Shelley's report stated that "a fair number [of respondents] mentioned male authority figures, with physicians and department heads the prime abusers" (p. 64). In response to the survey's results, training programs were developed to reach all levels of the organization.

Only two studies were found that tried to obtain representative samples of nurses. Grieo (1987) sent questionnaires to all licensed practical nurses and registered nurses in one county in Missouri, obtaining a usable response rate of 27 percent from 1,733 mailed questionnaires. Seventy-six percent of the respondents reported experiencing sexual harassment in the workplace. Patients were reported most often as the source of harassment (87 percent), followed by physicians (67 percent), coworkers (59 percent), and supervisors (8 percent). Cox (1987) reported on a study of verbal abuse, which included sexually harassing comments, encountered by registered nurses in hospitals. A questionnaire was mailed to 1,000 registered nurses from a mailing list of the Continuing Nursing Education Program of Texas Tech University's School of Nursing, with a response rate of 42.1 percent. Questionnaires were also mailed to 100 directors of nursing from a mailing list of the Texas Hospital Association's Society of Nursing Service Administrators, with a response rate of 57 percent. In introducing her findings, Cox stated, "Based on the frequency percentage results, verbal abuse is so prevalent in nursing it is surprising that any of us stay in nursing" (p. 49). Of the staff nurses, 82 percent reported verbal abuse. Among directors of nursing, 81 percent reported verbal
abuse in their experience, but this dropped to 77 percent in their roles as directors. The primary source of verbal abuse for both groups was physicians. Among other things, the author recommended that nursing turnover be studied to find out whether or not verbal abuse was a contributing factor.

While these five studies have methodological flaws and are generally noncumulative in both design and results, they do provide evidence of the existence of sexual harassment in health care settings. These nursing studies share two characteristics with the studies discussed from the medical literature. First, initial attention to the topic was directed to individuals in training situations. Second, one study in nursing (Cox 1987) and one in medicine (Silver and Glickman 1990) each considered sexual harassment as one aspect of the broader concept of abuse. Whether sexual harassment is a separate conceptual domain or is subsumed under the conceptual domain of abuse has ramifications for future investigations and interventions.

Steps for Intervention, Prevention, and Counseling, as Reported in the Nursing Literature

Few nursing articles offered specific interventions that could be taken by the victims of sexual harassment, preventive steps that could be taken by an organization, or counseling approaches for working with either the persons experiencing harassment or the individuals identified as exhibiting harassing behaviors. The few substantive articles describing interventions are reviewed next for two reasons. First, these articles health care researchers to the personal, organizational, and counseling strategies that have been tried, and have met with some apparent success. Second, these articles, as a set, highlight many areas for further research, such as the long-term impact on individuals of both the harassing experience and the interventions, whether or not the extent of sexual harassment in an organization changes through preventive activities, and the organizational conditions that support the various strategies.

The October 1986 issue of RN contained several articles on sexual harassment (Arbeiter 1986a, 1986b; Murphy 1986) directed to the general nursing audience. While patients were identified as the source of some sexual harassment, physicians were named as the most frequent harassers in these anecdotal reports. Strategies employed by the nurses in countering the harassment included direct commands to stop, laughing it off, and passive resistance by avoiding the harasser. Murphy encountered the subject when conducting interviews for a paper on health care management, but found the nursing victims unwilling to talk for fear of retaliation. Murphy notes, "Like the victims of rape, women who have been harassed tend to feel guilty. They often ask themselves what they might have done to 'cause' the incident" (p. 49). Direct confrontation of the harasser was recommended as a strategy for stopping the behavior and the phrase recommended for addressing physicians was, "I know what you're doing, doctor, and I resent it. Please stop so that we can resume a professional relationship" (p. 51). If a direct exchange with the harasser would be problematic, or if spoken admonitions were
ignored, the next step would be a letter of a "specific, polite, and controlled" (p. 52) nature. It was recommended that the letter be sent by registered mail with a return receipt requested, or delivered in person. If presented in person, it was recommended that a friend accompany the individual to confirm delivery. These recommendations were based on advice from Rowe (1981, 1985). For filing a formal complaint, it was recommended that a record be kept of the time, date, place, circumstances, and response for each incident. Attempts should be made to find witnesses and other victims. The article stated, "If your hospital is typical, it may not take your complaint seriously. You can almost assume that the administration will want to ignore your complaint if it names a doctor" (p. 53). If that occurred, readers were encouraged to consider going to their state or local civil rights agency, or to the federal Equal Employment Opportunity Commission to file a complaint within 180 days of the incident of harassment. As part of the investigation, the EEOC might decide to litigate the matter itself or to recommend that the individual initiate a lawsuit.

In a brief article, Grieco (1984) offered several suggestions for prevention. He recommended that management of sexual harassment be included in nursing education programs, and in new-employee orientations and continuing education programs offered at work. Educational programs should include role playing involving different levels of severity of sexual harassment. As a result, each person should be able to establish "personal boundary conditions beyond which an active response is indicated" (p. 172) and would know the follow-up process to take in their organization.

Spratlen (1988) provided the only account of sexual harassment counseling, which used investigative psychotherapy techniques. The approach involves development of written reports by the victim, using structured questions such as "What do you want to have happen as a result of reporting this incident?" (p. 30). According to Spratlen, the interactive process of developing the documents with the therapist buffers the self-blame and loss of self-esteem that usually accompanies the experience, allowing the victim to assume an active role in problem resolution. Similar support is available to the alleged harasser. A conciliation meeting is usually part of the process, attended by the victim, alleged harasser, department head, and therapist.

**SEXUAL HARASSMENT AS A FACTOR IN NURSING PRACTICE CONCERNS**

As noted earlier in this article, a question underpinning this investigation is whether sexual harassment has been considered as a contributing factor to nursing practice concerns. From 1970 through 1990, five major studies of nursing recruitment and retention were conducted under the sponsorship of various philanthropic, professional, and government organizations. None of the studies' reports addressed sexual harassment. However, these studies are briefly reviewed to provide further insights on the attention filters that seem to be operating in health care.

The National Commission for the Study of Nursing and Nursing Education reported on
its three-year investigation in 1970. Lysaught (1973), in reporting on the three-year implementation project that followed the investigatory phase, discussed discrimination in a section entitled "Sexism and Health Care." Sexual harassment was not specifically addressed. In contrast to subsequent investigations of nursing issues, this study did not emphasize professional relationships.

The three-year National Commission on Nursing, formed in 1980, had a specific charge to "analyze the forces influencing nurses' work environment" (1983, p. xiii). This report contains references to roles and relationships among nurses, physicians, and administrators. For example, "Mutual trust and respect for each other's roles is described by nurses and physicians who report satisfaction with their ability to work together in clinical settings" [emphasis added] (1983, 5-6). By inference, physicians and nurses not satisfied with their ability to work together must be experiencing a lack of respect, but the report does not operationalize respect in terms of specific interpersonal behaviors.

The two-year Institute of Medicine project (1983) was the result of a congressional mandate to objectively assess the need for continued federal support of nursing education; to recommend ways for improving the distribution of nurses to medically underserved areas; and to suggest actions that would encourage nurses to remain active in their profession, including recommendations involving practice settings conducive to the retention of nurses. In relation to the latter objective, the recommendations addressed issues of career advancement; salaries based on merit and experience; decision making about patient care, management, and governance; conditions of work; child care; compensation to encourage inactive nurses to become active and part-time nurses to increase their participation; the need for more nursing research; demonstration projects related to management approaches; and tracking of the supply and demand of nurses. The word "sexism" is used in a list of work-related issues (p. 201). This report also mentions relationship issues:

Surveys over the years have identified many reasons for discontent among nurses, often involving features of the nurse's work environment-internal relationships, scheduling problems, and physical aspects of the work setting. Without belittling these factors, attention should be paid to more fundamental problems .... There is, therefore, a need to develop the capacity of health care institutions and nurses to address issues in a mutually satisfactory manner. It must be recognized that some characteristics of nursing, particularly in hospitals, are inherently difficult. These include the close working proximity of occupations that have conflicting professional norms and perceptions. [emphasis added] (Institute of Medicine 1983, 198, 201)

The Magnet Hospitals study was different in objectives and style from the other national studies during this period. In 1981, the American Academy of Nursing, an organization of the American Nurses Association, appointed a Task Force on Nursing Practice in Hospitals. The task force recommended a study to identify hospitals that attract and retain professional nurses in order to assess the factors associated with successful
recruitment and retention (McClure et al. 1983). After a series of nominations and surveys of nominated hospitals, 41 were selected as "magnet hospitals" for in-depth study. In addition, follow-up interviews of nursing staff were conducted on a random sample of one-third of these hospitals in 1986 (Kramer and Schmalenberg 1988a, 1988b). In 1989, the chief nurse executives of 14 of the 16 hospitals that participated in the 1986 follow-up survey were interviewed by telephone (Kramer 1990). These interviews provided longitudinal information over a six-year period. The 1983 descriptive study included interviews with staff nurses chosen by their hospitals' directors of nursing to participate in the process. The interviews were conducted by a variety of individuals. The section summarizing interviews with staff nurses stated: "The question about nurse-physician relationships elicited a wide range of response from 'We have terrific physicians' to 'M.D.s are totally spoiled'' (p. 32). The word respect was used four times in the quotes of interviews with staff nurses and nursing directors and in the researchers' summaries. In December 1987, Department of Health and Human Services Secretary Otis R. Bowen formed a 25-member public advisory panel to provide advice on the problems related to recruitment and retention of registered nurses, and to develop action-oriented recommendations for immediate problems and long-range solutions involving the public and private sectors. Of the 16 recommendations, the ninth one most directly addressed relationship issues:

Employers of nurses, as well as the medical profession, should recognize the appropriate clinical decision making authority of nurses in relationship to other health care professionals, foster communication and collaboration among the health care team, and ensure that the appropriate provider delivers the necessary care. Close cooperation and mutual respect between nursing and medicine is essential. [emphasis added] (Secretary's Commission on Nursing 1988, vii, 34-35)

After noting issues related to scheduling, shift assignment, the increasing severity of patient illness, and technological advancements, the report observed that although these factors are obvious potential detractors from the nursing work environment, other, more subtle aspects contribute to nurses' overall perception of working conditions. These include nurse-physician relationships, nurses' autonomy within the organization, and employers' willingness to recognize the value of nurses' contribution as well as to invest time and money to improve nursing practice. [emphasis added] (Secretary's Commission on Nursing 1988, 13)

Under a section titled "Professional Image, Status and Prestige," the report specifically noted that "RN-physician relationships are an important determinant of RN job satisfaction" (p. 13).

Results from the review of the national studies of nursing are consistent with the findings of the qualitative review of journals. Each of these five studies addressed topics that could have included consideration of sexual harassment. In addition, the studies
consistently used the terms "respect" and "relationships," with few efforts at further explication. That the topic of sexual harassment is not even mentioned when the health care work environment is being analyzed-in national forums involving many people (e.g., panel members, staff, persons offering testimony, survey respondents) representing diverse disciplines-is a result requiring reflection, dialogue, and evaluation.

SUMMARY AND NEXT STEPS

Sexual harassment among health care personnel has received limited attention in the health care literature. The poignant silence with regard to this topic in the most prestigious journals of medicine, nursing, administration, and research should be a cause for concern. Since the literature is a major source of information on important issues provides knowledge for present and future members of the health care professions, the lack of mention of sexual harassment may indicate a blind spot that limits our ability to critically analyze recurring problems, demonstrated by review of the national studies that addressed nursing practice issues. As health care professionals begin to explore the issue of sexual harassment among health care providers, clear conceptual definitions need to be developed. In addition, several areas of investigation should receive immediate attention.

CONCEPTUAL DEFINITIONS

Three approaches have been used to define the concept of sexual harassment: (1) sexual harassment treated as a separate concept, (2) sexual harassment viewed as an aspect of sexuality, and (3) sexual harassment seen as one aspect of abuse.

Most of the organizational literature on sexual harassment treats the topic as a separate concept, probably as a consequence of history. Studies of sexual harassment began in the late 1970s (Farley 1978; Mac-Kinnon 1979) as an outgrowth of concerns about discrimination against women. While not specifically discussed in Title VII of the Civil Rights Act of 1964, sexual harassment emerged as a form of discrimination through judicial decisions (Julius and DiGiovanni 1990). The EEOC definition of sexual harassment, presented at the beginning of this article, is a broad, legal definition. Although proving some of its points-particularly that a sexually hostile environment exists-is difficult based on current case law (Regan 1989; Julius and DiGiovanni 1990), the EEOC definition provides specific categories for investigating sexual harassment. The investigations by Grieco (1987) and Griffin-Shelley (1985) are examples of sexual harassment studies in health care that used the legal definition approach.

Research and practice, while mindful of the legal definitions and determinations, should be able to address broader qualities of employment and professional relationships. Consequently, several efforts have recently been made to address sexual harassment as one aspect of sexuality, a concept that generally has been neglected within organization theory (Hearn and Parkin 1983; Burrell 1984; Hearn and Parkin 1987; Burrell and
Hearn 1989). Investigations of sexual harassment in health care have not addressed the topic in terms of sexuality.

In the health care literature, sexual harassment has been considered as one aspect of abuse (Cox 1987; Silver and Glickin 1990). While not consistent with the conceptual treatment of sexual harassment in the organizational literature, this approach may be the most constructive. Investigations related to the broader concept of what might be called "abuse of person" might prove more beneficial in furthering our understanding of behavioral causes, consequences, and approaches than the narrower sexual harassment/discrimination definition or the sexuality focus. For example, consider the situations where a woman or man makes disparaging comments about the sexual preferences or fidelity of an individual of the same sex to the individual or to others. While such incidents might not be included in the traditional definition of the "sexually hostile environment" in the legalistic approach to sexual harassment, they would be considered an abuse of person, and are worth addressing in order to improve professional relationships.

While "abuse" or "abuse of person" may be the fundamental concept that needs further definition, development, and investigation, the label is a negative one. Several authors in medicine and business have addressed "covenantal relationships," a positive label that captures a caring dimension generally espoused by individuals attracted to health care. May (1983) noted that contractual relationships are based on time-limited self-interest, in contrast to the continuous responsibility and personal identity of covenantal relationships. DePree (1989) reflected on the right to covenantal relationships, which are different from contractual relationships, in the employment setting:

Covenantal relationships fill deep needs, enable work to have meaning and to be fulfilling. They make possible relationships that can manage conflict and change. (p. 33)

DePree related covenantal relationships to intimacy. Similarly, a recent Lancet editorial (1990), which reviewed the doctor-nurse relationship and recommended that health professionals reflect on their practices together, was titled "A Suitable Case for Intimacy." Health care is a service provided through relationships: provider with client, provider with provider, and myriad day-to-day interactions among a wide variety of individuals. Therefore, defining sexual harassment as a breach of the covenantal relationship may be an approach with great appeal to health care professionals and, as a result, may elicit more participation in addressing the issue.

The three conceptual approaches to defining sexual harassment that were discussed may not be mutually exclusive, and other approaches may evolve. Tangri, Burt, and Johnson (1982) have proposed three explanatory models for sexual harassment at work-natural/biological, organizational, and sociocultural-which have elements congruent with both the sexuality in organizations approach and the covenantal relationship approach. Popovich and Licata (1987) have suggested a role episode
process that may be congruent with each of the three current approaches. Terpstra and Baker (1986) have focused on the cognitive processes that result in the perception of sexual harassment. Given the embryonic stage of conceptual treatments, a variety of approaches to defining sexual harassment can be explored, contributing to both health care and organization theory.

AREAS FOR EXPLORATION

Although many aspects of sexual harassment require investigation, only a few areas needing immediate attention are highlighted in this discussion. First, sexual harassment incidents are rarely reported to supervisors (Duldt 1982). What are the situational and organizational characteristics that impede or facilitate reporting? If individuals feel at risk for reporting sexual harassment in their organizations, how many staff know that the EEOC and local civil rights offices may be helpful? While it is understandable that an employer would want employees to use internal channels, do policies and procedures mention these external avenues as alternatives?

Surveys of organizational climate, employee satisfaction, and other related issues are used in many organizations. Items related to sexual harassment need to be developed by methodological researchers for inclusion in these surveys. As such measures are introduced, more needs to be known about changes in the frequency with which sexual harassment incidents are reported, the organization's responses to the reported incidents, and ways in which responses to the measures change over time. There may be few responses the first time such measures are used, but more incident reports may subsequently be made by a few of the staff. The majority of employees may adopt a "wait-and-see" stance until the organization's commitment to addressing the behavior of individuals can be determined, particularly if a few powerful individuals are the major offenders. There may be minimal responses to sexual harassment measures until educational sessions are offered to explain the behaviors that constitute sexual harassment. With reliable and valid measures, repeated over time, an organization can determine the impact of various interventions on the extent and characteristics of sexual harassment. The health care field would be helped by case studies from organizations that undertake internal evaluations and interventions.

Another area for immediate investigation concerns therapeutic interventions and the long-term healing of individuals who experience harassment of varying severity. Spratlen's (1988) investigative psycho-therapy approach includes a conciliatory meeting. Does an individual who has the opportunity to work through the issue with the person whose behaviors were perceived as harassing more easily achieve closure and resolution? Do such strategies result in both individuals remaining in the organization, or at least in the field? In our organizations, who can best serve as the facilitator for such conciliatory sessions?

CONCLUSION
While the empirical work on sexual harassment in health care is sparse and the study samples generally rely on self-selection for respondents, it seems reasonable to conclude that sexual harassment does exist in health care settings and that further work is required to understand its causes, manifestations, effects, and optimal interventions. Some investigators may want to explore the incidence and prevalence of sexual harassment in health care compared to other fields. Before doing so, serious thought should be given to what quantifications will be most useful. Gutek (1989) observed that the research on sexual harassment in the United States tends to focus on the frequencies and definitions of sexual harassment, mostly to the benefit of the legal profession. Studies related to prevention, identification, and resolution of sexual harassment might have more long-term effects on improving the practice environment than would a preoccupation with frequencies.

Finally, the articles on sexual harassment were usually written by one or more members of a professional group for its own audience. The overtones, cliches, and accusations contained in some presentations should be a source of concern to all professionals. Discipline-specific studies are not likely to contribute to either a comprehensive understanding of the issue or a broad-based consensus on prevention intervention. Further, any standard of conduct that evolves with respect to sexual harassment should transcend disciplinary boundaries. Therefore, as this important topic is addressed in various health care management, research, and policy forums, the deliberations and inquiries must be of an interdisciplinary nature.

ACKNOWLEDGMENTS

The encouragement to pursue this topic came from a variety of sources, but I would like to give special thanks and acknowledgment to Thomas D'Aunno, Ph.D. and John C. Peirce, M.D. for the "covenantal relationships" that supported the inquiry.

TABLE 1 Perceptions of Third-Year Medical Students: Experiences of Sexual Harassment and Observations of Sexual Misconduct

<table>
<thead>
<tr>
<th>Source</th>
<th>Sexual Harassment (%)*</th>
<th>Sexual Misconduct** (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Slurs</td>
<td>Advances</td>
</tr>
<tr>
<td>Classmates</td>
<td>45</td>
<td>16</td>
</tr>
<tr>
<td>Preclinical faculty</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>Clinical faculty</td>
<td>65</td>
<td>32</td>
</tr>
<tr>
<td>Residents/interns</td>
<td>61</td>
<td>35</td>
</tr>
<tr>
<td>Nurses</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Patients</td>
<td>48</td>
<td>26</td>
</tr>
<tr>
<td>At least one source</td>
<td>81</td>
<td>55</td>
</tr>
</tbody>
</table>


*Percent of 31 women students reporting at least one episode of sexual harassment or mistreatment.

**Percent of 75 medical students reporting observation of at least one episode of what they believed to be ethical or professional misconduct.

FIGURE 1 Title, Publication Frequency, and Circulation for Reviewed Journals

<table>
<thead>
<tr>
<th>Journal</th>
<th>Publication Frequency</th>
<th>Circulation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Journal of Nursing (AJN)</td>
<td>Monthly</td>
<td>314,000</td>
</tr>
<tr>
<td>Hospital &amp; Health Services Administration</td>
<td>Quarterly</td>
<td>23,000</td>
</tr>
<tr>
<td>Health Care Management Review</td>
<td>Quarterly</td>
<td>3,400**</td>
</tr>
<tr>
<td>Inquiry</td>
<td>Quarterly</td>
<td>3,500</td>
</tr>
<tr>
<td>Journal of the American Medical Association (JAMA)</td>
<td>Weekly</td>
<td>372,000</td>
</tr>
<tr>
<td>Journal of Nursing Administration (JONA)</td>
<td>Monthly</td>
<td>13,309</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Monthly</td>
<td>3,200</td>
</tr>
<tr>
<td>New England Journal of Medicine</td>
<td>Biweekly</td>
<td>226,000</td>
</tr>
<tr>
<td>Nursing Research</td>
<td>Bimonthly</td>
<td>11,000</td>
</tr>
</tbody>
</table>


** Source: Aspen Publishers, Rockville, MD.

GRAPH; FIGURE 2 Distribution of 94 Articles from Qualitative Review of Journals

AR = Administration/Research Journals: Hospital & Health Services Administration, Healthcare Management Review, Inquiry

N = Nursing Journals: American Journal of Nursing, Journal of Nursing Administration, Nursing Research

M = Medical Journals: JAMA, Medical Care, New England Journal of Medicine

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