Australian registered nurses describe the health care workplace and its responsiveness to sexual harassment: An empirical study

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Abstract

This report is a summary of findings from a 1995 study of Australian registered nurses and their perceptions of their health care workplaces, especially as it relates to sexual harassment. There is little Australian-based empirical research available to guide hospitals and health care facilities in developing appropriate policies regarding sexual harassment. Additionally, hospitals have few assessment tools at their disposal to determine if policies and procedures are well known and effective. As the major employer of registered nurses, hospitals and health care facilities need to be concerned about employees' perceptions of the workplace.

Introduction

Sexual harassment, mired in power, politics and historical tradition, is shrouded in silence in nursing (King 1995) and this is particularly so in the Australian health care industry. There is little empirical research, discussion or assessment of Australian hospitals to determine the effectiveness of policies and procedures that aim to reduce or eliminate sexual harassment. With few exceptions, it has been necessary to rely on studies conducted overseas to evaluate the extent of sexual harassment and the responsiveness to it by Australian health care organisations.

Two widely quoted studies of sexual harassment are the 1981 United States Merit Systems Protection Board (MSPB) study of 20 000 federal employees, and a

follow-up survey in 1987. These studies found that sexual harassment was widespread, with 42 per cent of all female employees and 15 per cent of all male employees reporting sexual harassment in the workplace. Their findings indicated that the targets of sexual harassment were generally unaware of any formal procedures for dealing with sexual harassment in their organisation, and were sceptical about their effectiveness. The MSPB findings also indicated that most victims of harassment thought that there was much the employer could do to reduce sexual harassment. Few victims pursued formal remedies, but many who did found them useful (US MSPB 1981, 1988).

Sexual harassment and registered nurses

Several overseas studies have explored sexual harassment experienced by nurses. These studies have found that sexual harassment of nurses is widespread (Donald & Merker 1993; McMillan 1993; Finnis & Robbins 1994). These studies, which describe a variety of harassers in the workplace (for example, medical officers, patients, co-workers and supervisors), found most harassers to be male. These studies support the view that registered nurses, like most women in the workplace, experience some form of sexual harassment during their working life. Seventy-seven per cent of the Kentucky registered nurses who reported experiencing sexual harassment did not formally report their complaints (Donald & Merker 1993). Interestingly, the same percentage of respondents perceived that their employers did not have formal policies to deal with sexual harassment in place. In the Finnis and Robbins (1994) study, the majority of the respondents took no action (confronting or reporting) in response to sexual harassment. These findings supported the larger MSPB study.

Australian registered nurses seem to experience similar harassment in the health care workplace. A recently published Australian study (Madison 1995a) found that two out of three registered nurses described experiences of sex-based or sexual harassment, and identified doctors, co-workers and supervisors as the most common harassers. The most frequently described harassing behaviour (more than one kind of behaviour could be identified) was 'unwanted sexual teasing, jokes, remarks or questions' followed by 'unwanted and deliberate touching, leaning over, cornering and pinching' and 'unwanted sexually suggestive looks or gestures'. Only 4 per cent of the respondents had used the formal organisational procedure for dealing with sexual harassment (Madison 1995b).

Definitions of sexual harassment

There is considerable variation in a precise definition of sexual harassment between the different anti-discrimination statutes throughout Australia, but they all describe unwelcome and unsolicited behaviour of a sexual kind, which detrimentally affects a person's ability to participate in various aspects of employment and education (Marles 1990). Any attempt to sustain power by treating members of the opposite sex as sexual objects and inferiors, while 'acceptable' in the past, is now clearly defined as sexual harassment in the workplace (Goodner & Kolenich 1993). The Australian Law Reform Commission (1993) describes sexual harassment as consisting of (1) unwanted sexual attention or (2) the creation of an inappropriate sexual atmosphere in the workplace. These two definitions are important for health care facilities. The first, unwanted sexual attention, focuses on the experience(s) of an employee, while the second focuses on the workplace 'atmosphere'.

The first description of sexual harassment includes such behaviour as demands for sexual favours of various kinds, touching, sexual jokes and displays of erotic pictures (Marles 1990). Confusion exists in perceptions of harassment, with some individuals unaware that patronising and degrading remarks can be included in sexual harassment. According to Gutek (1985), part of the confusion is that men describe fewer types of behaviour as harassing than do women. Further, sexual harassment can be context-related and is frequently ambiguous (Marles 1990). Marles describes situations where one individual may find certain behaviour (in certain contexts) offensive and another may not.

A hostile, harassing workplace

Importantly for employers, the second description addresses the inappropriate 'sexualised' workplace atmosphere (Marles 1990). Sexual harassment occurs most often in a 'sexualised' workplace where 'banter', innuendo, sexist jokes and patronising behaviour are commonplace. Julius and DiGiovanni Jr (1990) describe the employer's obligation to evaluate their work environment to determine if it is 'sexually hostile'. They state that if the sexist or sexualised nature of the workplace is sufficiently severe or pervasive, employers must act. Importantly for health care facilities, Marles (1990) describes the group behaviour which usually involves a subordinate female work group which gains approval or status from responding favourably or challengingly to mild sexual suggestions or behaviour, as leading to increased sexual interaction within a work setting. This dynamic, she suggests, promotes behaviour that would normally be distasteful to participants on an individual basis.

The demarcations between acceptable banter, workplace frivolity, sexist and sexual jokes, sexual suggestions and innuendo, and sex-based and sexual harassment are difficult for employers and employees alike. However, it is an employer's responsibility to create a work environment that is free from hostility, offence and harassment (Childers-Hermann 1993; Goodner & Kolenich 1993; Neuhs 1994). This is particularly difficult in a workplace that is known for its 'off the wall humour' and one where registered nurses continue to be stereotyped as sex objects (Muff 1982; Madison & Gates 1996). The confusion and differences in perceptions about what constitutes sexual harassment affect the preventative focus suggested as critical to organisations in reducing sexual harassment.

Employers and sexual harassment

The prevention of a harassing or hostile work environment through appropriate education is the best approach to reducing or eliminating sexual harassment in the workplace (Marles 1990; Goodner & Kolenich 1993; Neuhs 1994). This education can consist of development and dissemination of policies and procedures to deal with harassment, workshops for supervisors and employees, assessment of the workplace for explicit or offensive materials, and visible reinforcement of organisation-wide commitment to a discrimination-free workplace (Bovet 1993).

The Law Society of British Columbia Gender Bias Committee (1992) suggests another approach for employers to consider in addressing sexual harassment in the workplace. It describes three prerequisites for eradicating sexual harassment. Firstly, sexual harassment must no longer be condoned by employers. Secondly, a realistic method of obtaining redress is necessary in the workplace. Thirdly, professionals must recognise that sexual harassment is a serious impediment to women's ability to participate equally in their professions.

Employers must display a strong anti-sexual harassment attitude, or risk appearing to condone sexual harassment or a hostile and intimidating workplace (Goodner & Kolenich 1993). When employers evaluate their workplace for offensive and hostile characteristics, they may mistakenly use the number of complaints as an assessment tool. In fact, few victims of harassment use formal or informal complaint procedures (US MSPB 1981, 1988; Madison 1995b). Individual women can sometimes internalise the fact that sexual harassment is normal, believing that 'everyone does it'. Therefore, if every woman experiences it, a complaint is not justified (Ussher 1992). Gutek (1985) also notes the tendency for many organisations to conclude that harassment is virtually non-

existent by labelling the target who complains as a 'troublemaker', instead of attempting to reduce or eliminate a hostile and harassing environment.

Although a positive and productive workplace would be the goal of most organisations, there is *also* increasing evidence that explicit policies and internal complaint procedures can help protect an organisation from liability for managing a hostile work environment (Julius & DiGiovanni Jr 1990). Health care organisations, with their complex hierarchical and patriarchal organisational structures, must seek constantly to evaluate their workplace practices for efficiency and effectiveness, particularly practices relating to sexual harassment. The study reported in this paper would suggest that a proactive educational, preventative program would serve Australian health care facilities well, as they attempt to understand and combat this costly workplace problem.

Methods

Research design

The quantitative design for this research project was a descriptive, retrospective, exploratory survey. It collected broad demographic information such as age, sex, workplace and employment status. It used one open-ended question to elicit additional opinions and perceptions from the sample population.

Respondents

Students enrolled in advanced tertiary preparation in nursing, counselling and health care management at a New South Wales university were used as the participants in this study. Registered nurse students who agreed to participate in the survey represented nurses practising in a variety of settings across Australia. Three hundred and seventeen surveys were distributed to all registered nurses in attendance at a two-day conference-style meeting.

Data collection procedure and analysis

Convenience sampling was used; all registered nurses were invited to participate. The required university ethics committee approvals were sought and granted. Three hundred and seventeen surveys were distributed on the first day of the two-day meeting and participants returned their completed surveys by the end of the second day. This paper presents data analysis, using frequency and percentiles, as it relates to registered nurses' perceptions of the Australian health care workplace.

Instrument

The United States MSPB 1981 and 1987 survey tool was modified to reflect the Australian nursing and health care workplace. Spelling and language changes such as, 'X the box' (American) to 'tick the box' (Australian) were necessary. In modifying the tool, the role of the medical officer was added in several places where it was not present in the MSPB surveys. The survey questions regarding experiences of sexual harassment were not limited to recent occurrences (within the last two years) in this study as they were in the MSPB studies. The original MSPB study underwent rigorous testing for validity and reliability. Eight registered nurses from a variety of practice settings piloted the modified Australian survey for comprehensibility and evidence of ambiguity. Following appropriate suggestions, changes were made to the instrument. The survey was 15 pages long, contained 56 questions, with most questions containing several sub-questions. A cover letter accompanying the survey addressed anonymity and confidentiality issues.

Findings

Table 1 provides information about the respondents. Sixty-two per cent of those surveyed responded, with females making up almost 92 per cent of the participants. In addition, 65 per cent of the respondents described working in a metropolitan setting, and 28 per cent described a rural or remote setting.

Table 1: Demographics of respondents

317 registered nurses surveyed
197 responded (62%)
Gender
13 (6.6%) males
181 (91.9%) females
3 (1.5%) no response

Of the respondents who described sexual harassment experiences, only 7 per cent indicated that they took 'formal action' by requesting an investigation by their organisation, lodging a discrimination complaint or lawsuit, or lodging a grievance or adverse action appeal. Respondents were asked to identify reasons for not taking formal action and encouraged to tick all boxes that applied. Table 2 notes the reasons for not taking formal action.

Table 2: Reasons for not taking formal action (n = 131)

I saw no need to report it	40.5%
I thought it would make my work situation unpleasant	26.0%
I did not think anything would be done	25.2%
I did not know what action to take	19.8%
I was too embarrassed	19.8%
I thought it would be held against me or that I would be blamed	11.5%
I did not want to hurt the person who bothered me	6.1%
I though it would take too much time and effort	5.4%

A series of questions was presented to all respondents, about either the workplace where sexual harassment had occurred or, if they did not report harassment, their present work setting. The respondents were asked how much they agreed or disagreed with descriptions of their immediate work group (the people with whom they work(ed) most closely on a day-to-day basis). The following results were collapsed to combine those who responded in the affirmative or negative. Twenty-three per cent of the respondents to this question did not feel free to bring up general work-related concerns or suggestions to their immediate supervisor. Twenty-five per cent of the respondents to this question did not feel that their supervisor would attempt, if possible, to correct general work-related concerns.

Several questions were designed to make some determinations about the level of sexualised behaviour in the workplace. Only 3 per cent of those who responded to this question felt that they were expected to flirt in the workplace and only 5 per cent felt that they were expected to make sexual comments about the opposite sex.

Although two out of three respondents reported experiencing sexual harassment in the workplace, 73 per cent stated that uninvited and unwanted sexual attention *was not* a problem where they work(ed). Seventy-four per cent disagreed that employees use(d) their sexual favours for advancement on the job at work. Only 46 per cent agreed that their organisation made every effort to stop unwanted sexual attention amongst its employees.

A series of questions focused on the organisation and the respondents' perceptions of sexual harassment education, policies and procedures that they believed were, or were not, available in their health care workplace. Table 3 identifies the responses.

Table 3: Respondents' view of the organisation (n = 197)

Does your organisation have a formal policy for dealing with sexual harassment in the workplace?	
Yes	52.8%
No	13.7%
Don't know	32.5%
No answer	1.0%
Does your organisation encourage employees to protest formally against harassing behaviour through an established procedure?	
Yes	45.1%
No	19.8%
Don't know	34.0%
No answer	1.0%
Would you agree or disagree that your organisation seems to resent dealing with sexual harassment?	
Agree	15.2%
Disagree	36.0%
Don't know	46.7%
No answer	2.0%
Have employees within your organisation been formally trained concerning what constitutes sexual harassment?	
Yes	23.4%
No	39.6%
Don't know	35.5%
No answer	1.5%

All respondents were then asked to describe their perceptions of education of medical officers regarding sexual harassment. Finally, respondents described their understanding of the presence or absence of a formal policy to govern relationships between medical staff and employees (see Table 4).

Table 4: Respondents' view of the medical staff (n = 197)

Has the medical staff associated with your organisation been formally trained concerning what constitutes sexual harassment?	
Yes	8.1%
No	26.4%
Don't know	62.9%
No answer	2.5%
Does the medical staff associated with your organisation have a formal policy to govern relationships among medical staff and employees of your organisation?	
Yes	23.4%
No	3.0%
Don't know	69.5%
No answer	3.0%

Only 1 per cent of respondents thought that there was little that management could do to reduce sexual harassment on the job. They were asked which of the following would be the most effective actions for an organisation's management to take regarding sexual harassment. Respondents could tick all actions that applied (see Table 5).

Table 5: Effective actions for organisations (n = 197)

Establish and publicise policies which prohibit sexual harassment	92.4%
Conduct swift and thorough investigations of complaints of sexual harassment	90.4%
Publicise the availability of formal complaint channels	88.8%
Provide training for managers and equal employment opportunity officials on their responsibilities for decreasing sexual harassment	86.8%
Establish a special counselling service for those who experience sexual harassment	83.2%
Provide awareness training for employees on sexual harassment	83.2%
Enforce penalties against those who sexually bother others	79.2%
Enforce penalties against managers who knowingly allow this behaviour to continue	68.0%

Discussion

Sexual harassment complaints

Almost one in four respondents indicated that they did not feel they could bring up general work-related concerns with their supervisor. If registered nurses do not feel comfortable bringing up general concerns to their supervisor, they can hardly be expected to bring up such serious concerns as sexual harassment. Only 7 per cent of the respondents indicated that they took formal action when confronted with sexual harassment. These two responses should make health care organisations aware that the absence of complaints about unwelcome sexual attention in the workplace should not be used as an indicator of the absence of inappropriate behaviour in the workplace. The literature supports the view that few victims of harassment actually report the behaviour or use formal reporting procedures. The number of complaints should therefore *not* be used as a guide to determine the extent of harassment in a workplace.

The ambivalence that registered nurses associate with sexual harassment is noted in this survey as two out of three respondents report harassment, yet 73 per cent of the respondents did not believe sexual harassment was a problem at work. Several explanations regarding this finding could be developed. One interpretation is that these registered nurse respondents found sexual harassment endemic in the workplace and less than half saw employers as concerned and making every effort to stop harassing behaviour. Registered nurses do not always take active steps to 'fight' the stereotypes that persist and are depicted in the popular media. They need to evaluate their responsibility for the professionalism found in their workplace. When harassing behaviour occurs, do registered nurses 'encourage' its repetition by failing to speak out actively and assertively against it? Do they accept it as 'part of the job' or do heavy workloads and job responsibilities consume the energy that would be required to combat widespread sexual harassment in the workplace?

Organisational policies

Forty-six per cent of the respondents did not know or did not believe that their organisation had a formal policy for dealing with sexual harassment in the workplace. In the current environment, with well-established legislative requirements in place, one would assume that quite adequate policies should exist in all health care organisations, even in the most rural and remote establishments, and certainly in every metropolitan hospital. If such policies and procedures are in place, it would seem that in many instances they are very poorly advertised.

Organisational education

Three-quarters of the respondents did not know or did not believe that employees in their organisations had received education about sexual harassment in the workplace. This question is important because it goes beyond policies and procedures and focuses on education concerning what constitutes sexual harassment. Organisations need to acknowledge the confusion that exists about what constitutes sexual harassment and take steps to educate all health care workers and health care professionals. The literature implies that prevention of sexual harassment is far superior to any 'cure' and that organisations will be better served with a strong preventative, educational program in place.

Almost 90 per cent of the respondents did not know or did not believe that the medical staff associated with their organisation had been formally trained concerning what constitutes sexual harassment. The harasser most commonly identified by the respondents in this survey was the medical officer (Madison 1995a). This being the case, it would behove health care organisations and medical officers themselves to consider the most effective (and visible) strategy to educate medical officers, or medical students, in what constitutes harassing behaviour. The literature suggests that perceptions about what constitutes harassment vary between individuals. In the absence of a concerted and focused organisation-wide educational effort, these misperceptions will be perpetuated. Far better a preventative group educational program than an after-the-fact individual effort.

Almost three-quarters of the respondents did not know or did not believe that a formal policy to govern relationships among employees and medical staff existed. Developing a policy of this sort could be an effective and positive interdisciplinary project, within which an open and non-threatening discussion about not only general professional relationships, but also inappropriate sexualised behaviour, could occur. It is unreasonable to expect compliance with a standard that is not clear, in writing and accepted by the various professionals involved.

A disturbing finding appears to be that less than half of the respondents felt that their organisation makes every effort to stop sexual harassment. This observation about the workplace would suggest that even if policies and procedures exist, and management profess appropriate behavioural expectations, these efforts appear ineffectual. Is sexual harassment addressed directly in orientation and induction programs? Has the chief executive and governing body spoken out formally against harassing behaviour in the workplace? Are posters and pamphlets about sexual harassment readily available to all staff? Neither is it reassuring that 62 per cent of respondents believe that, or don't know if, their organisation resents

dealing with sexual harassment. According to these respondents (see Table 5), there were many effective actions for an organisation's management to take regarding sexual harassment. The registered nurse respondents were keen to see that educational approaches as well as swift and thorough investigations of complaints were based on well-publicised policies. The findings associated with this study are a powerful message to health care organisations. There should be no doubt about the inadequacy of current approaches to sexual harassment in Australian health care facilities. Registered nurses seem to find the approach unsatisfactory and inadequate. Hospitals, health care facilities and health care professionals would be wise to assess their own workplaces and work towards more effective sexual harassment education, policies and procedures.

Conclusion

The findings of this survey are not reassuring to health care executives or health professionals. It would appear that registered nurses believe that current efforts to educate employees and health care professionals about sexual harassment are inadequate. If policies and procedures regarding sexual harassment exist, they are not well known to registered nurses. A significant amount of harassing behaviour is perceived by registered nurses and little is seen in the workplace in the way of education or preventative policies. These findings seem to say that registered nurses perceive the health care industry as failing to take sexual harassment problems seriously. In contrast, this survey should be reassuring to many registered nurses. They are not alone in perceiving sexual harassment and 'their problems' are not isolated. These registered nurse respondents believe health care organisations fail to recognise that a hostile and harassing work place is vulnerable to the manifestations of sexual harassment. Clearly, according to these registered nurses, the Australian health care industry's efforts must be directed towards prevention of sexual harassment through well-publicised, organisation-wide education.

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