

Bullying as Gender Harassment: Discrimination in the Operating Room

Susan Strauss RN Ed. D

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As the Human Resources manager, you have just had another OR nurse come and complain about how some of the surgeons yell, throw instruments, and swear in the OR. You're concerned, knowing that the behavior could mean something serious. You know that sexual harassment and abuse to nurses by physicians is well documented in the literature. One of the specialties where nurses experience abusive behavior by physicians, such as yelling, swearing, and throwing objects, is in operating rooms. What else do you need to know so you can act ethically and legally?

Recent, first of its kind, research suggests that the abusive (bullying) behavior that physicians direct toward female and male registered nurses in the operating room may not be bullying after all, but rather illegal gender-based sexual harassment and discrimination to the female nurses. A (Midwestern) state-wide study examined physician bullying behavior to RNs that is often reported in operating rooms to determine if there was a difference in the pervasiveness, severity, and impact of the behavior based on the gender of the nurse. The gender disparity was apparent suggesting that female nurses who are bullied may actually be experiencing gender-based sexual harassment and discrimination. The study's results have far reaching liability implications to hospitals and physicians because unlike bullying, federal law prohibits harassment and discrimination.

Female and male RNs and anesthesiologists completed a questionnaire in which they identified the frequency and severity of personally experiencing 20 different unwelcome bullying type

behaviors. Because the Civil Rights Act Title VII and the Equal Employment Opportunity Commission (EEOC), which outlaws discrimination and harassment, recognize that an employee does not need to be the direct target of harassment in order to be victimized by it, the questionnaire also asked the nurses to identify the frequency and severity of the same 20 behaviors that they *witnessed*. In addition, the nurses indicated the gender of the physician bully/harasser, and what, if any, impact the behavior had on their work. And finally, nurses were asked to write about a personal experience and to share any additional information they felt was important.

Interestingly, male RNs were more likely to *experience* three, and *witness* one of the 20 behaviors more frequently than their female colleagues (See table). However, female RNs were much more likely to identify many of the behaviors as severe, unlike their male counterparts. The women nurses *experienced* 12 and *witnessed* 14, of the 20 behaviors as severe (See table). As the table demonstrates, the abusive behaviors ranged from what may be considered minor--*experienced my contributions being ignored and not given praise I deserved*, to potential criminal behavior such as *experiencing threats of physical harm; being shoved, pushed, or bumped into with unnecessary force; being slapped, struck, or grabbed; or had an object thrown in the room or at me*. Alarming, 10% of the female nurses personally experienced these more severe forms of abuse; none of the male nurses reported experiencing any of these behaviors. Another 10% of the female nurses and 6% of the male nurses *witnessed* the violence. The women were targeted significantly more than the men demonstrating gender based harassment.

Nurses specified the frequency of experiencing and witnessing the unwelcome behavior from *never* to *daily*; and identified the severity of each behavior experienced and witnessed on a scale from, *not at all* to *extremely*. Consider that if one female RN *experiences* even a couple of

the 20 different behaviors, for example weekly, in addition to her *witnessing* several of the 20 different behaviors weekly, and these behaviors are perceived as severe, the totality of her exposure to the behavior indicates that she may be a victim of harassment or discrimination! But wait, you say, these behaviors aren't sexual, how can this be considered sexual harassment?

The Civil Rights Act (amended in 1997) and the Equal Employment Opportunity Commission (EEOC) hold that in order for behavior to rise to the level of illegal sexual harassment, it must be unwelcome, severe and/or pervasive enough to interfere with an employee's ability to do their job and create a hostile work environment. The behavior must also be based on the individual's sex or be gender-based. Gender harassment is the term coined by Dr. Louise Fitzgerald and her colleagues (1995) when behavior is hostile and degrading to women (or men, but more likely to women) and is not sexual in nature. Men and women's perceptions about gender harassment vary with men less likely to consider the behaviors as harassment. Behavior that is considered gender harassment does not have to be sexual in nature (despite the fact that it is a form of sexual harassment) in order for it to be a violation of Title VII.

Gender harassment is abusive behavior directed at a woman or a group of women because of their gender. This is true even if the behavior does not include sexual comments, language, or behavior, yet where the behavior is severe and/or pervasive enough to create a hostile work environment. Because gender harassment may be severe and or pervasive enough to interfere with a woman's ability to do her job, the behavior meets the legal standard for employment discrimination. Gender harassment, as a type of sexual harassment, is a violation of Title VII of the *Civil Rights Act*, according to the EEOC.

With rare exception, physician bullying/gender harassment was done in front of other OR team members such as the certified surgical technician (CST), nurse anesthetist, the RN circulating nurse, perhaps a physician's assistant or RN first assistant, and even a medical device representative. The physician's harassment, then, victimizes not only the direct target of his (both female and male RNs indicated that male physicians are the usual bully, though male nurses indicated that occasionally female physicians bullied as well) abusive behavior but victimizes all others in the OR who are forced, by their mere presence, to experience his abuse all well. Also present is the patient who may be anesthetized, sedated, or neither. As one patient was wheeled into the OR hearing his surgeon berate one of the nurses, the patient told the surgeon that because of his abusive behavior to the nurse, there was no way the surgeon would be operating on him and to get him (patient) out of that OR.

The female RNs were much more likely than male RNs to indicate that experiencing and witnessing the bullying/harassing behaviors impacted their work. The women perceived physician gender harassment as a serious problem, a serious strain on daily work, that it reduces efficiency, decreases morale, reduces job satisfaction, increases errors, interferes with work relationships, diminishes teamwork, and that it contributes to staff turnover, absenteeism, and the nursing shortage.

A significant finding in the study was that male nurses claimed that they are treated better and provided with job advantages because of their gender. The female nurses noted worse treatment and job disadvantages due to their gender. These are significant discriminatory findings, especially considering that nursing is a female dominated career, yet men have the advantage. One of the women stated that there was a "good ole boys club of male bonding between the male nurses and male physicians." Both female and male nurses discussed the

difference in the way each gender is treated by male physicians with male nurses generally receiving *friendlier* treatment than their female colleagues as exemplified in this woman's statement, "...male nurses develop almost a 'buddy' relationship with male MDS..." A male RN agreed with her, "With the gender issue, I feel as a male, I do seem to get treated with better respect."

Female RNs addressed gender differences in aggressive treatment by physicians to nurses, "I think male doctors and male nurses bond differently than male to female. I believe that some male doctors think they can intimidate some females easier." Male nurses agreed as demonstrated by this man's perspective, "What I've noticed throughout my career is male MDs don't treat RNs the same. They're somewhat more aggressive toward female RNs than male RNs." And another male nurse stated, "I've been in nursing 35 years and I know I'm favored based on my male gender. "

One of the most alarming findings of the research was the negligence displayed by management and administration to nurses' complaints of bullying/harassment. Though many nurses indicated that their OR was much more respectful than it had been several years ago, the vast majority of nurses' assertions focused on management's failure to intervene on the bullying/harassment, or if they did intervene, the intervention was ineffective. Often nurses indicated that the abusive behavior was typical of a certain physician who was not held accountable by administration even when administrators or managers were informed of his behavior, often because of the physician's political and/or financial power within the organization. One female nurse cited an incident in which a surgeon verbally attacked her, grabbed her by the shoulder, and pushed her around in front of the director. "She [director] was a direct witness to this assault and did nothing about it!!" Nurses indicated that management knew

of the abusive behavior of many physicians but would not stand up to them because they brought business to the hospital. Nurses disclosed that management told them that nothing of consequence would happen to the surgeons because they are the “money makers.” This is potentially illegal behavior.

The hospital is liable for physician harassment of an employee even if the physician is not a hospital employee. An employer is strictly liable for harassing behavior by a supervisor or by an individual reasonably perceived as a supervisor. Physicians, as the perpetrator, may be viewed as a supervisor by nurses who reasonably believe that physicians have the power to impact their job up to and including termination. As a result, this increases the liability to the hospital and to the physician.

Nurses wrote that physician abuse has been a problem in the OR for decades. One woman stated, “This is a very hush-hush environment that exists, I’m sure, in every operating room across the country on some scale.” Many nurses expressed hope that the results of the research would positively impact the abusive OR environment. Other nurses addressed the study from an affective perspective, “It saddens me that this kind of research even needs to be done ,” while another stated, “It really made me think about my work environment. I could feel my BP [blood pressure] rise and tightness in my stomach.” Other nurses contacted the researcher indicating their unwillingness to complete the questionnaire because it was too painful.

The EEOC and various courts have stated that unwelcome behavior must be severe and/or pervasive enough that a *reasonable person*, in the same or similar environment or circumstances, would find it created a hostile or abusive environment. The context in which the harassment occurred should be considered, recognizing that the behavior does not occur in a vacuum. The reasonable person standard recognizes that even if offensive conduct is the norm, it

may still constitute a hostile work environment; even if employees state that the conduct is to be expected, is part of the job, or is harmless, as nurses have indicated in other research. Some of the female nurses viewed the everyday sexism and bullying as just rudeness and failed to see the injustice in the behavior.

According to the *Ellison v. Brady* (1991) opinion, the reasonable person standard fails to recognize the divergent views between most women and men. This standard reflects the perspective of appropriateness through a hidden male biased lens and fails to recognize the fact that most victims of sexual harassment are women. As a result, a *reasonable woman* standard has been applied in many courts.

A 2005 9th Circuit Court opinion in *EEOC v. NEA Alaska*, held that it wasn't necessary for harassing conduct to be sexual in nature in order to violate Title VII, if the harasser treats men and women differently or if the behavior impacts women differently than it does men. The court adapted the "reasonable woman" standard in this opinion when the conduct of a male administrator to his female and male workers was not sex or gender specific, but impacted the women more severely than it did the men. Like physicians, the administrator was verbally abusive to both men and women by frequently yelling, using profanity, shaking his fists at them, and using intimidating body language. His behavior to the men was less severe and he and the men also enjoyed a collegiality and male camaraderie the administrator did not share with the women with whom he worked, as was also evident with the male nurses and male physicians. Even though the administrator had been a bully to the men he worked with, this case demonstrates that there is no such thing, in many courts, of the "equal opportunity harasser." This case serves as a warning light to hospital human resources professionals.

As early as 1985, gender harassment was heard in the Court of Appeals for the District of Columbia Circuit which decided in *McKinney v. Dole* that physical violence that is not sexual could be sex-based harassment if it demonstrates unequal treatment that would not have taken place if it was not for that employee's gender. This opinion was the first to introduce the concept of gender-based sexual harassment, meaning that if a hostile environment exists for one gender, even if the hostility is not sexual in nature, it may constitute sexual harassment. *Andrews v. City of Philadelphia* (1990), and *Hall v. Gus Construction Co.* (1988) further defined hostile environment when they stated that intimidation and hostility toward women, because they are women, could violate Title VII. This was followed by the EEOC (1990) claiming that harassment doesn't have to involve sexual activity or language but needs to demonstrate a persistent pattern directed to employees because of their gender.

Yoder & Aniakudo (1996) claimed that, "the gender-typing of an occupation, the gender composition of the work groups, and the organizational climate regarding gender, all may impact on what is perceived as harassing behavior" (p. 254). The authors stated that these issues are broader than the workplace and reflect societal factors. Judge Goodwin's opinion in *EEOC vs. NEA Alaska*, stated that bullies may take advantage of a predominantly female work environment (as in healthcare) because the bully is allowed to bully women, whom he is more comfortable abusing than men. The judge opined that, "There is no logical reason why such a motive is any less because of sex than a motive involving sexual frustration, desire, or simply a motive to exclude or expel women from the workplace (p. 12111)."

What does this mean for you as the HR professional in the prevention and intervention of gender harassment and bullying? What are your responsibilities in cases of physician (or any employee) gender harassment and bullying? What additional steps may be required considering

that nurses do not come forward and inform you of the behavior? The following crucial steps will minimize the amount of gender harassment and discrimination and bullying from occurring and therefore decrease your risk of liability.

- Review your hospital harassment policy every year and revise it as needed to stay current with ever evolving case law; be sure that the policy includes harassment related to all protected classes
- Ensure that your hospital's harassment policy includes a gender harassment definition and a sample of behaviors that constitute gender harassment; include examples of misconduct that would constitute harassment based on any protected class
- Create a Workplace Conduct Policy that clearly prohibits any abusive bullying behavior
- Disseminate the policies and actively communicate the policies to all employees and physicians on a yearly basis
- Conduct a comprehensive harassment and bullying training for all supervisors, managers, senior management, administration, and physicians every 18 months by a subject matter expert. Do not use online training programs
- Conduct harassment and bullying training for all employees every 2 – 2 ½ years.
- Follow your policies
- Ensure that whoever investigates claims of harassment and/or bullying has been adequately trained, recognizes gender harassment (and any other protected class-based harassment) and is a competent investigator
- Partner with medical directors, senior administration, and the physicians group practices to collaborate in the prevention and intervention of physician abusive behavior insuring

that it not occur or continue even if it requires terminating a physician's privileges or employment

- Include the hospital's harassment and workplace conduct policies, including consequences to physicians who harass and bully, in the medical staff by-laws and enforce them
- Work with OR management to assess the OR climate and physician behavior by proactively interviewing nurses regarding physician behavior. Act on the results of the assessment where appropriate to stop the gender harassment and bullying.
- Counsel managers and administrators about the consequences and potential liability for failure to hold physicians accountable for gender harassment and bullying.

Female nurses are experiencing gender harassment and discrimination by male physicians according to the research discussed in this article. As Human Resources professionals, you play a pivotal role in the prevention and intervention of this abusive behavior. Implementing the steps discussed will not only minimize the behavior, but will positively impact the OR environment thereby improving morale, decreasing errors, and improve patient care.

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Survey of Experiences of Female and Male RNs in Their Perioperative Practice

1. Experienced jokes said at my expense. 1,2,3,4
 2. Experienced demeaning, derogatory remarks, name-calling. 4
 3. Was ignored or excluded from professional camaraderie. 4
 4. Had object thrown in room or at me.
 5. Was slapped, struck or grabbed.
 6. Experienced “silent treatment.” 3,4
 7. Was not given praise I deserved. 1,3,4
 8. Experienced rude and/or disrespectful treatment. 3,4
 9. Experienced hostile gestures, glaring, or body language 3,4
 10. Experienced being yelled or shouted at 3,4
 11. Experienced my contributions ignored 3,4
 12. Was prevented from expressing myself (interrupted; told to shut up).
 13. Experienced MD flaunt status, treat me in a condescending manner 3,4
 14. Was shoved, pushed, or bumped into with unnecessary force
 15. Experienced reprimands, criticism, “put downs” in front of others 4
 16. Experienced sexist or negative remarks or jokes about women 3,4
 17. Experienced sexist or negative remarks or jokes about men 1,4
 18. Experienced unfair blame or was scapegoated 3
 19. Experienced sexual remarks, jokes, or innuendo 3,4
 20. Experienced threats with physical harm
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¹ Behaviors male nurses experienced; ² Behaviors male nurses witnessed;

³ Behaviors female nurses experienced as severe; ⁴ Behaviors female nurses witnessed as severe