Sexual Harassment in the Pharmacy: Recent Findings and Implications for Practice and Education

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The purpose of this study was to determine the prevalence of sexual harassment among female pharmacists; to assess how practitioners respond to occurrences of sexual harassment; and to evaluate the impact of sexual harassment on the pharmacy manpower pool. A survey instrument was developed and administered to 1200 randomly selected female pharmacists in Illinois. Seven hundred and eleven usable surveys were returned for a response rate of 59 percent. Survey results indicate that 47 percent of the respondents experienced one or more incidents of sexual harassment in either their previous job or their current job. The majority of these experiences were categorized as "suggestive looks," "sexual remarks," or "unwanted attention." Two percent experienced severe incidents of harassment such as "grossly inappropriate touching", "rape or attempted rape." The harasser was just as commonly reported to be a patient, a colleague, or a supervisor. However, colleagues were more likely to be the offenders for the more serious two percent of the incidents. Twenty-four percent of the respondents reported the incident to their supervisors, 15 percent found employment elsewhere, and seven percent changed work shifts or duties to avoid the harasser. Responses to sexual harassment are described. Data suggests that sexual harassment is a significant problem in the pharmacy and can negatively impact productivity. Implications for practice and education are described.

INTRODUCTION

Since the Anita Hill/Clarence Thomas Senate hearing, sexual harassment has received considerable public and private scrutiny and attention. The U.S. courts have defined two types of sexual harassment in the workplace:

1. "quid pro quo" harassment—tying employment decisions to requests or requirements for sexual favors or conduct, and;
2. "hostile environment"—engaging in sexual conduct that creates an intimidating, hostile, or offensive environment.

Further, the Equal Employment Opportunity (EEO) Commission, a federal agency responsible for protecting workers from job inequities, defines sexual harassment as: "Unwelcome sexual advances, requests for sexual favors, and other verbal and physical conduct of a sexual nature constitute sexual harassment when: (*i*) submission to such conduct is made either explicitly or implicitly a term/condition of an individual's employment; (*ii*) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such an individual; or (*iii*) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment."

Recently in the Harris vs. Forklift Systems, Inc. case, the Supreme Court ruled that an employee does not have to prove psychological injury or related damages to establish a hostile work environment. It is up to the court to determine if the conduct is sexual in nature, physically threatening or humiliating, as opposed to merely offensive. In addition, the court reviews the conduct and determines if the conduct unreasonably interferes with the employee's work performance and the severity and frequency of the conduct. Justice Sandra Day O'Connor wrote that the victim does not have to "suffer a nervous breakdown" to prove sexual harassment(1). The court system and federal guidelines have clearly defined sexual harassment in the workplace.

In the health sciences, sexual harassment has been identified as a problem for female physicians, dentists, and nurses. It typically develops in environments in which men hold dominant positions when compared to female counterparts. Pharmacy colleges have witnessed a tremendous change in student demographics over the last decade. Given that pharmacy colleges now nationally average 63 percent female student enrollment(2), and that women comprise 38 percent of working pharmacists(3), we believe that sexual harassment may be, if not already, a problem among female pharmacists. In addition to the changing gender composition in the profession of pharmacy, the profession itself is evolving away from the drug product orientation and toward a patient care orientation. Pharmacists are presently, and are likely to increase their time spent in direct patient

care. Thus, similar to medicine and nursing, pharmacists may begin to experience occurrences of sexual harassment by patients.

Sexual harassment could potentially have a detrimental effect on pharmacy manpower. To avoid sexual harassment, female pharmacists may switch jobs or stop working, or leave the profession entirely. Alternatively, female pharmacists may attempt to deal with such problems on their own, which may produce negative psychological or physical symptoms that could lead to medical problems, and reduce productivity or professional commitment. Any of these actions would impact negatively on the pharmacy workforce. While the pharmacy manpower issue may not be as pertinent today with corporate downsizing, robotics, and health care reform, prudent managers recognize the costs involved in staff turnover, and strive for an environment that is conducive to long-term staff stability.

Therefore, the purpose of this study is to determine the prevalence of sexual harassment among practicing pharmacists; to assess how practitioners respond to occurrences of sexual harassment; and to evaluate the impact of sexual harassment on the pharmacy manpower pool.

LITERATURE REVIEW

Generally, sexual harassment occurs in health care settings due to institutional hierarchies, and the prevalence of men in positions of greater power. Sexual harassment is more related to power and abuse of this power, consciously or unconsciously, than it is to sexual attraction(4,5). Those employees in "lower" positions of the hierarchy are less likely to report sexual harassment due to the fear of affecting their job status. Historically, more women experience sexual harassment than men. Sexual harassment can include anything from offensive comments, unwanted attention or advances, offensive body language, and unwanted physical advances, to sexual bribery.

Sexual harassment is a major cause of stress for women workers(6) and can produce significant and deleterious effects on work productivity of employees. Victims have reported decreases in work performance, development of stress-related complaints, *e.g.,* tension headaches, nervousness, and development of physical illnesses. On a long term basis, other victims report switching jobs within their institutions, while others opt to resign from their positions so as to leave behind a hostile work environment(7–9).

Increasingly this issue has been examined in the medical literature. Female physicians experience sexual harassment from patients, colleagues, or from attending physicians. Because physicians are perceived as powerful and in control, this threatens some men who respond by using sexual harassment to regain their sense of masculinity. Role stereotyping may also promote sexual harassment. That is, men are considered aggressive, self-confident, and powerful, while women with similar characteristics are considered to be nasty, strident, emasculating, and stubborn. Three studies have addressed some of these problems(10–12). They consisted of confidential questionnaires which were sent to medical students, interns, and residents; and practicing physicians. In one study, 75 percent of female physicians reported being harassed at some point during their careers, mainly verbally by their own patients and in their own offices(10). In another study, 73 percent of female medical residents, as opposed to 22 percent of male medical residents, experienced sexual harassment during their medical college or residency training programs. Of those females who were harassed, 79 percent felt that the incident impaired their work performance(11). At the time that the incident occurred, few women reported sexual harassment due to: (*i*) fear that the harasser would not be punished and that the victim would be blamed; (*ii*) fear of retaliation; (*iii*) shame, guilt, or loss of self-esteem; (*iv*) fear that professional progress would be affected. In the third study, 55 percent of female medical students, residents, and practicing physicians who responded to a survey reported experiencing unwanted sexual attention sometime within one year of the data collection period. Interestingly, approximately one-third of respondents were unaware of ways to remedy the situation at their respective institutions. Also, sexual harassment was documented to have a significant impact on job-related stress and to reduce the organizational commitment of the victims(12).

Many female physicians feel as though their self esteem is tied with the profession due to the large amount of commitment involved in training. Female physicians feel as though they will not be considered professional if they complain; or that they may have misinterpreted the behavior and thus, the event was due to her own shortcomings. More than half of the physicians who reported experiencing sexual harassment by their patients continued to provide care for them.

Nurses seem to face more sexual harassment than any other health science professional, although this may be due to the higher percentage of women in this field. Many blame themselves and feel as though they are too friendly. If they confront the harasser, they sometimes feel even more guilty. One study done on nursing students showed 71 percent of sexual harassment complaints were due to verbal comments from male faculty(7). The impact of such acts included: (*i*) deleterious effects on work performance, (*ii*) a negative impact on psychological health; (*iii*) a negative impact on physical health. Again, very few victims reported the incidents. Most nurses did not report sexual harassment because they felt as though they would not be believed; they were concerned that reporting would affect their careers; they were worried that it would affect their work environment; or they felt that the victim would suffer retaliation or be blamed.

Other studies in the nursing literature focus on what to do if sexual harassment occurs(13). Some examples include: (*i*) education, *e.g.,* workshops or seminars directed at providing information concerning institutional policies and procedures that prohibit harassment; (*ii*) avoidance behaviors, *e.g.,* counseling on how to dress or act so as to minimize harassment, guidelines concerning ethical standards of conduct; and (*iii*) practical ways to deal with the harasser.

A specific problem with dentists is that most practice in a private setting which makes sexual harassment even more difficult to define and prove. A study done on female dentists and dental students found that about 50 percent experienced sexual harassment from colleagues and patients(8). The literature appears to focus on management once harassment occurs. For example, the literature recommends keeping written records of all incidents that occur(14,15).

There are currently only three published articles on pharmacists. One is a case report of a female pharmacy technician who was harassed by a pharmacist supervisor(16). The other two are commentaries discussing the legal aspects

Table 1. Description of the sample

Variable	N[a]	Percent[b]
Age		
≤30 years	171	24.1
31-35	140	19.7
36-40	162	22.8
41-45	98	13.8
46-50	58	8.2
≥51	82	11.5
Ethnicity		
Caucasian	618	86.9
African-American	28	3.9
Hispanic	6	0.8
Asian	49	6.9
Other	10	1.4
Marital status		
Single	192	27.0
Married	518	73.0
Number of children		
None	278	39.3
1 or more	430	60.7
Degree		
BS	586	82.4
PharmD	125	17.6
Hours per week of work		
<10	28	4.3
11-20	72	11.0
21-30	77	11.8
31-40	202	30.9
41-50	238	36.4
>50	37	5.7
Practice setting		
Community — independent	96	14.7
Community — chain	222	33.9
Community hospital	137	20.9
Teaching hospital	100	15.3
Industry	16	2.4
HMO	3	0.5
Other	80	12.2

[a]N=711.
[b]Percentages may not equal 100 percent in each variable group.

of sexual harassment in the workplace(17,18). With the recent changes in gender composition of practitioners and changes in the way pharmacy is practiced, there is an interest in defining the prevalence and impact of sexual harassment on pharmacists as individuals, and on the pharmacy manpower pool.

METHODS

Survey. A survey instrument was developed to assess personal characteristics of the respondents, practice setting and job content characteristics, occurrences of sexual harassment, personal impact of sexual harassment, and responses to sexual harassment. The items designed to assess incidents of sexual harassment were taken from research assessing the prevalence of sexual harassment on physicians, medical students, and residents(10,11). To assure that the respondents had a common understanding of the terms used to assess sexual harassment, a definition list was attached to the survey. The respondents were asked to report incidents of sexual harassment in their current job and in their previous job. The survey was pilot tested on several faculty and pharmacy residents to determine that the questions were clear and unambiguous. Minor modifications were made based on the pilot test. The survey also included space and instructions for the respondent to "tell their story" if they so desired.

Table II. Number of individuals who reported incidents of sexual harrassment by type of incident[a]

	Previous job	Current job
Sexual remarks of offensive comments	159	131
Suggestive looks	104	84
Unwanted attention	87	59
Brushing, touching, or grabbing	79	55
Pressure for dates	54	30
Suggestive gestures	29	17
Unwelcome explicit propositions	26	20
Offensive displays	21	24
Grossly inappropriate touching	22	7
Inappropriate gifts	11	9
Suggestive exposure of body parts	7	6
Sexual bribery	7	3
Rape or attempted rape	3	0

Procedure and Sample. The survey was mailed, along with a personally signed, detailed cover letter, and a return postage paid self-addressed envelope to 1,200 randomly selected licensed female pharmacists. As a token of appreciation, a one dollar bill was enclosed in the mailing. The sample was selected from a 1993 listing of pharmacists registered in the State of Illinois, provided by the Illinois State Board of Pharmacy. The sample represented rural and urban settings, as well as a variety of different practice settings. Nonrespondents were sent a follow-up letter and another copy of the survey four weeks later.

Analysis. Data was analyzed using the SPSSX computer program(19). Descriptive statistics were run to assess prevalence of sexual harassment, responses to incidents of sexual harassment, and the profile of victims of sexual harassment.

RESULTS

One hundred and sixteen surveys were returned undeliverable. Seven hundred and eleven usable surveys were returned for a response rate of 59 percent. The sample can best be described as 40 years old or younger, Caucasian, and married. About 75 percent of the respondents worked over 31 hours per week. Almost half of the respondents worked in community settings, and 36 percent working in hospital settings. The rest were distributed among industry, health maintenance organizations and other settings. A complete description of the sample is presented in Table I.

Almost half (N=337, 47 percent) of the respondents reported experiencing at least one incident of sexual harassment in either their previous job or their current job in pharmacy. The incidents ranged from suggestive looks and sexual remarks or offensive comments, to grossly inappropriate touching and rape or attempted rape. Only 10 women reported incidents of sexual bribery or quid pro quo type of harassment. The remainder (N=327) experienced incidents of sexual harassment of the hostile environment type, *i.e.,* when repeated occurrences of conduct creates an intimidating, hostile, or offensive working environment. The frequency

Table III. Source of harrassment[a]

	Previous job				Current job			
	Patient	Supervisor	Colleague	Other	Patient	Supervisor	Colleague	Other
Suggestive looks	25	32	36	11	37	10	28	9
Sexual remarks or offensive comments	27	53	74	13	39	31	62	9
Suggestive gestures	6	11	13	1	7	0	8	2
Offensive displays	4	5	13	1	5	4	12	3
Inappropriate gifts	4	2	5	1	4	2	4	0
Pressure for dates	11	12	26	8	13	5	9	4
Unwanted attention	21	20	36	11	25	8	19	8
Unwelcome explicit proposition	3	9	12	3	6	6	9	1
Sexual bribery	0	4	2	1	1	0	0	2
Suggestive exposure of body parts	2	1	4	1	1	1	4	0
Brushing, touching, or grabbing	7	32	33	8	14	11	27	5
Grossly inappropriate touching	2	9	9	4	2	3	1	1
Rape or attempted rape	0	1	1	1	0	0	0	0

[a]Many individuals reported multiple types of sexual harrassment, so N > 337.

of incidents of sexual harassment across almost every type of incident, declined from previous job to current job. Interestingly, the respondents reported experiencing sexual harassment from patients almost as frequently as from supervisors or colleagues. Table II presents frequencies for each type of incident, and Table III presents the source of the harassment.

The respondents expressed a wide variety of reactions to incidents of sexual harassment. Emotional reactions ranged from fear to amusement. Anger was the most frequent emotional reaction reported (42.1 percent). The majority of respondents reported that the incident of sexual harassment as "mild, not a big deal" (70 percent). Approximately 28 percent of the respondents reported the incident(s) as "annoying and troubling", and two percent reported the incident(s) as "severe, interferes with my work and well being." Table IV presents a complete description of reactions to incident(s) of sexual harassment.

Responses to, or actions taken after the incident(s) of sexual harassment varied considerably. Twenty-four percent of the respondents who experienced sexual harassment in the workplace reported the incident(s) to their supervisor. When asked why they did not report the incident(s) to their supervisor, the majority of women (67.6 percent) responded that they dealt with the problem and did not need help. Their methods of dealing with the problem ranged from avoidance such as changing work shifts or employment, confiding in a close friend or family member, to confronting the harasser directly. It is not clear, from the survey results, if the method(s) of dealing with the problem actually attempted to change the behavior of the harasser, or if the women focused on changing their behavior to adjust to the situation. Other women chose not to report the incident(s) because they were not confident they would be believed (4.8 percent), or feared retaliation (6.6 percent). Several women wrote in the space provided that they were afraid of being perceived as troublemakers or thought of as overreacting. One woman wrote "when my supervisor's supervisor was told of the harassment, he told me I was overreacting and that the supervisor who was doing the harassment wasn't doing anything wrong! He then told me I may be in the running for a promotion, but that position never came about. I took this as a bribe to placate me." Several other women wrote that at the time of the incident,

Table IV. Reaction to incidents of sexual harrassment

	N	Percent
Emotional response		
Fear	27	7.9
Anger	144	42.1
Indifference	73	21.3
Amusement	18	5.3
Other	79	23.1
Physical response		
Physically ill	2	0.6
Mentally ill	14	4.1
Both physically and mentally ill	4	1.2
Neither	317	93.0
Describe incidents of sexual harrassment		
Mild, not a big deal	238	70.0
Annoying and troubling	95	27.9
Severe, interferes with my work and well being	7	2.1

public awareness of sexual harassment was much different, and they did not know that it was a workplace issue that could be reported. For example, one woman wrote "but then we didn't know much what to do, except try to avoid these people." The hierarchy in the health sciences became apparent in some women's responses to sexual harassment. Several women wrote that their harasser was an MD, and therefore "untouchable." When asked what was the result of their response to the incident of sexual harassment, 59.3 percent of the respondents reported that their action stopped any further incidents of sexual harassment from that individual from occurring. Again, it is not clear from the survey results if the respondents' actions were directed at changing their own behavior to adapt to the situation, or to change the behavior of the harasser. Table V presents a complete description of responses to incidents of sexual harassment.

Incidents of sexual harassment appear to have an impact on pharmacy manpower issues. Fifteen percent of the respondents reported finding employment elsewhere after the incident occurred. Another seven percent reported changing work shifts to avoid the harasser, and approximately three percent reported taking more time off work because of the incident(s) of sexual harassment. Table V describes the impact of sexual harassment on pharmacy manpower.

Table V. Responses to incidents of sexual harrassment

Variable	N	Percent
Reported incident to supervisor		
Yes	81	24.0
No	259	76.0
Told close friend or family		
Yes	214	63.0
No	126	37.0
Confronted harrasser directly		
Yes	157	46.4
No	181	53.6
Did not report incident because:[a]		
Not confident I would be believed	14	4.1
Dealt with problem and did not need help	196	58.1
Feared retaliation	19	5.7
Felt shame or guilt	5	1.5
Other	55	16.3
No response	48	14.3
Action stopped further incidents of sexual harrassment		
Yes	200	59.3
No	121	35.9
No response	16	4.8
Took more time off		
Yes	8	2.8
No	329	97.2
Changed work shift or duties to avoid harrassment		
Yes	25	7.4
No	310	92.6
Found employment elsewhere		
Yes	51	15.0
No	288	85.0

[a]Response to this question is greater than 259. It may be because respondents misconstrued "reporting" to be either to supervisor or police.

Respondents were also encouraged to write comments or "tell their story" on the back of the survey if they so desired. Several themes emerged from the comments. The first theme was the difficulty of managing sexual harassment when the harasser was a patient or customer. While it is questionable whether or not sexual harassment from clients or customers fits the legal definition of sexual harassment, nevertheless respondents expressed concern over keeping the customer and providing the best care for the patient. When the patient/customer sexually harassed the pharmacist, providing professional service and care became very difficult. Several respondents reported that retail pharmacy customers were the worst. One respondent said: "In retail pharmacy chain stores, some male customers demand an inordinate 'explanation or lengthy' discussion on the sale of condoms." A second respondent said: "I've been kissed, grabbed, threatened...all by male patients..." Another respondent candidly said: "The main problem that I have had with harassment has been with patients. I have found it very difficult to deal with it because you want to keep the person as a customer, yet protect yourself."

A second theme that emerged was the number of women who had not experienced sexual harassment, but had witnessed it in the workplace. One respondent said: "One of my pharmacy technicians has a patient who goes out of his way to pat her on the buttocks each time he comes in to the pharmacy. He is an older male about 65 and she is about 35. She stays behind the counter when she sees him coming, but once he actually stepped behind the end of the counter to pat her butt." Another respondent said "most of the actions were directed at younger staff members—especially the technicians, and were what the male supervisor considered harmless fun."

Several women commented that the heightened awareness of sexual harassment was overblown. One woman said: "I appreciate your survey, but don't blow the results out of proportion. We live in a real world with real people. I've seen women harass men as well. Having worked as a pharmacist for 25 years, I see no serious pattern of harassment by either sex." Another said: "The more I hear about these sexual harassment lawsuits, the more I am reminded of someone yelling whiplash in a car accident as a get rich quick scheme...I think things are just getting out of hand and more ridiculous by day."

LIMITATIONS

The study has several limitations. First, respondents were asked to report incidents of sexual harassment in their current job and in their previous job. These jobs may have spanned just a few years for the younger pharmacists in the sample, or they may span several decades for the older pharmacists in the survey. However, given the relatively young age of the sample, and the recent phenomena of women entering the profession, the authors suspect that the incidents reported occurred relatively recently. While there may be currently a heightened awareness of sexual harassment, nevertheless the definition of sexual harassment in the workplace has not changed over the lifespan of the respondents in this study. It is now simply less acceptable. A corresponding limitation is the study's reliance on respondent recall.

The study, by design, examines women's perspectives of sexual harassment. Granted, for a more complete picture of the phenomena, men's attitudes and responses would also have to be examined, however, that was not the focus of this study.

CONCLUSION

Clearly the results of this study indicate that sexual harassment in the workplace is occurring in pharmacy practice, and occurring to a large number of female practitioners. Quid pro quo, the first type of sexual harassment defined by the courts, does not appear to be as problematic in pharmacy as the hostile environment issue, the second type of sexual harassment defined by the courts. Repeated occurrences of suggestive looks and sexual remarks, unwanted attention, offensive comments, and brushing, touching or grabbing are the most frequent types of incident(s) of sexual harassment, which create a difficult and hostile work environment for women. Therefore, it appears that the shifts in employment patterns are the result of hostile environments, rather than quid pro quo sexual harassment. The data indicate that incidents of sexual harassment have decreased from previous job to current job. That may be because women are leaving environments where sexual harassment occurs and finding employment elsewhere, or it may be the effect of history. In other words, awareness of sexual harassment has increased over recent years, thus decreasing the number of occurrences. Alternatively, some practice environments may be more conducive to incidents of sexual harassment than others. The relationship between type of practice environment

and incidents of sexual harassment needs to be explored.

In spite of the clear-cut federal laws and guidelines regarding sexual harassment in the workplace, relatively few women chose to report the incident to their supervisor. Their reasons for not reporting the incident ranged from "not confident I would be believed" to "feared retaliation" while the majority reported that they dealt with the problem and did not need help. Dealing with the problem ranged from avoidance behaviors to confrontational behaviors. It is disturbing that the majority of women who have experienced sexual harassment do not report the incident to their supervisor. Workplace laws and guidelines are of no assistance to employees if unfair or discriminatory behavior is not reported.

Many states, like Illinois, may have a Department of Professional Regulations (DPR) which monitors professional standards. The DPR in Illinois hears cases regarding sexual harassment and processes complaints. However, the DPR is not uniquely devoted to pharmacy. It is charged with monitoring professional standards for a multitude of professions. The study did not ask women if they reported the incident to the DPR, but only if they reported the incident to their supervisor or to the police. However, conversations with representatives from the DPR indicate that they receive few sexual harassment complaints.

IMPLICATIONS FOR PRACTICE AND EDUCATION

Respondents recommended better on-the-job training about identifying and managing sexual harassment, and better supervision of employees. Many said that supervisors and employers need a better understanding of sexual harassment. Employers need to thoroughly understand their legal responsibilities in resolving issues of sexual harassment in the workplace, and the impact of sexual harassment on individual performance and productivity. Supervisors and managers need to be aware of the detrimental effect sexual harassment has on women's productivity, which in turn affects the level of service in the unit. One respondent said: "Sexual harassment is an overwhelming problem in the workplace. Little attention is given to this issue. Employers should be clear to employees that this type of behavior is unacceptable on day one."

Respondents recommended better training about identifying and managing sexual harassment while in pharmacy school. Educators can use case studies of sexual harassment in law and ethics classes, and use examples of sexual harassment in communication classes. This awareness and training would assist women in dealing with potential incidents of sexual harassment in their future professional practice. It would also heighten awareness of sexual harassment and its effects for male students as well.

Pharmacy faculty and administrators also need to demonstrate sensitivity to and awareness of sexual harassment. Pharmacy faculty serve as important role models to students. If pharmacy faculty demonstrate that sexual harassment is not appropriate or acceptable behavior through their attitudes and behaviors, than students may learn to model that behavior.

Pharmacists, as other female health professionals, experience sexual harassment from patients, colleagues, and supervisors. While the law provides protection for women employees from sexual harassment from workplace supervisors and colleagues, it is unclear what rights women care-givers have with regard to experiencing sexual harassment from a patient or a customer. Many women respondents recognize a fine line between providing care, keeping a customer, and protecting their own rights. This problem is not unique to pharmacists. Physicians and dentists have both reported sexual harassment by patients and have discussed the dilemmas it involves. Again, training and education while in pharmacy school, particularly in communication classes, may give young women the skills that they need in order to deliver pharmaceutical care in spite of the barriers of sexual harassment.

Since the late 1980s, pharmacy college enrollment has been comprised of approximately 60 percent women. This trend does not appear to be dissipating. In addition, individual pharmacists are spending more time in direct patient care and counseling; and communications is being emphasized. In order for pharmacists to provide pharmaceutical care and to perform at their full potential, pharmacy managers need to ensure a safe and secure environment in which to practice. Moreover, educators need to provide students with the training and skills needed to effectively deal with the problems and situations presented by a variety of patients and customers.

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