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Exploring Factors Associated With the Incidence of Sexual Harassment of Hospital Nurses by Patients

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Abstract

Purpose: To identify factors affecting nurse-perceived sexual harassment and specific types of patient sexual behavior experienced by Japanese nurses.
Design: Cross-sectional questionnaire study of Japanese hospital nurses.
Methods: Self-administered questionnaires (N=600) were distributed to Japanese hospital nurses, and 464 were returned (response rate of 77.3%). Two instruments were used: one was for determining sexual harassment by patients, and the other was for determining specific types of patient behavior that had sexual connotations.
Findings: Registered nurses were at a much higher risk of sexual harassment than were nurse assistants. In addition, registered nurses had a much more positive attitude toward gender equality compared with assistant nurses.
Conclusions: A positive attitude toward gender equality mediated by a relatively high education level might be associated with increasing reports of sexual harassment. An increasing incidence of sexual harassment claims among nurses should prompt hospital organizations to take proper action against it. Education on gender equality was thus considered a long-term solution for reducing the sexual harassment of Japanese hospital nurses.
Clinical Relevance: Establishing a safer working environment could enable nurses to provide better care for patients and thereby promote the development of good relationships between nurses and patients.

Hospital nurses tend to be more prone to the risk of sexual harassment than are staff members in other workplaces. Many studies on sexual harassment in the healthcare industry in Western and non-Western countries have shown that sexual harassment of nurses is common in hospitals (Bronner, Petretz, & Ehrenfeld, 2003; Chuang & Lin, 2003; Fiedler & Hamby, 2000; Kiza & Dziegielewski, 2002; McKenna, Poole, Smith, & Coverdale, 2003; Shaikh, 2000). The results of these Western and non-Western studies have indicated that hospital nurses often encounter sexual harassment in daily clinical settings.

Several studies have been conducted to indicate factors or risks associated with sexual harassment of nurses. Results have shown that female gender (Bronner et al., 2003; Fielder & Hamby, 2000), job title (Fielder & Hamby, 2000), level of experience, such as student nurse versus staff nurse (Bronner et al., 2003), length of employment (Bronner et al., 2003), physical-care duties (Robbins, Bender, & Finnis, 1997), and traditional stereotypes relating to female nurses (Madison, & Minichiello, 2004) are central factors associated with sexual harassment of nurses.

Although these studies have been successful in indicating several important factors associated with sexual harassment, research into identifying the factors that pose the greatest risk has been lacking, and many other important factors have not been investigated. In addition

to relevant factors indicated in previous studies, specific attitudes of nurses, i.e., their empathic understanding toward patients and their attitude toward gender equality, were identified as previously not researched, but hypothesized to be relevant factors in this study.

Empathic understanding toward patients is an idea originally derived from psychotherapy and was highlighted by Rogers (1975), who considered it to be embracing the client's internal frame of reference, which includes perceptions, ideas, meanings. Currently, this approach is strongly advocated in Japanese nurses, both in educational preparation and in daily clinical settings. As a result, the majority of Japanese nurses are now requested to use this empathic approach when interacting with patients (Pang et al., 2003). However, this approach might not always be suitable, especially for situations in which a risk of sexual harassment is present (Hochschield, 1983; Smith, 1992). For instance, when extending empathic understanding in inappropriate situations, nurses might have to tolerate sexual harassment instead of refusing it.

Another important factor that might affect the incidence of sexual harassment is nurses' views on gender equality. If nurses have no awareness of gender equality, when they encounter some types of patient behavior, they might fail to label it accurately as sexual harassment (Madison, & Minichiello, 2000). Thus, nurses' views on gender equality were believed to affect the extent to which sexual harassment was reported in this study. In addition, in cases of sexual harassment, the most effective method of control is to show an unequivocal refusal (Libbus & Bowman, 1994). This entails, on one hand, a belief in gender equality; however, on the other hand, it does not require empathic understanding. Thus, in this study, the relationships of empathic understanding and nurses' views on gender with the prevalence of sexual harassment among nurses are examined.

The purpose of this study was to explore the factors that are most likely to contribute to the incidence of sexual harassment toward hospital nurses working in Japan. With this goal, the following variables were analyzed: sociodemographic factors, such as age, marital status, and having children; job-related factors, such as length of employment, administrative position, hospital management style; physical care; and nurses' attitudes such as empathic understanding, and gender equality. Exploring the factors most relevant to the incidence of sexual harassment is critical for formulating effective interventions and policies for Japanese hospital nurses.

Background

The following definition of sexual harassment was adopted: "Any unwanted, unreciprocated, and unwelcome behavior of a sexual nature that is offensive to the person involved, and causes that person to be threatened, humiliated, or embarrassed" (International Labor Organization [ILO], International Council of Nurses [ICN], World Health Organization [WHO], Public Services International [PSI], 2002, p. 4).

Recognizing or labeling any behavior as "sexual harassment" is dependent on the somewhat subjective perception of the person, as exemplified by the terms "unwanted" and "unwelcome" in the definition. Therefore, to assess sexual harassment with more external and visible criteria (Madison & Minichiello, 2000), a tool that was focused on patients' behavior was also included in this study.

The definition and policy of sexual harassment were brought to Japan from the United States (Mackinnon, 1979) and became widespread in the latter half of the 1980s. Since then, several government offices, large businesses, and universities in Japan have developed guidelines against sexual harassment (Fukushima, Nakashita, Suzuki, Keneko, & Ikeda, 1998). Thereafter, two pioneering academic studies indicating sexual harassment among Japanese female hospital nurses were conducted in 1998 (Abe, Matsuoka, & Kurita, 1998) and 2002 (Sasaki & Hara, 2002). Abe et al. (1998) reported an incidence of 49.4%, and Sasaki and Hara (2002) reported an incidence of 40%. These studies showed that female Japanese nurses are often subjected to sexual harassment in their daily work environments.

In between these two studies, in 2001, the International Council of Nurses' (ICN) statement regarding workplace violence, including sexual harassment, was translated into Japanese by the Japanese Nursing Association (JNA; 2001). More recently, the JNA conducted a survey on workplace violence, including sexual harassment, and in 2006, published guidelines for workplace issues in the healthcare industry (JNA, 2006a).

Sexual harassment in Japan is much more common with female nurses than with male nurses. According to the JNA (2006b), of approximately 800,000 nurses employed in 2004, approximately 30,000 were male, indicating that the percentage of male nurses employed was below 4%. Traditionally, nursing has been considered a female occupation (Fiedler & Hamby, 2000), and even now, the majority of Japanese nurses are female, except for those in special fields, such as psychiatric nursing. Thus, the present study is focused primarily on female nurses.

Methods

Assessment of Sexual Harassment and Behavior

Two instruments were used in this study. One was concerning sexual harassment and the other was concerning specific types of patient behavior that had sexual connotations, which was classified into specific categories.

Participants were asked whether they had ever encountered sexual harassment from patients and had the option of answering, *Yes* or *No*. However, the reported incidence of sexual harassment depends on a nurse's individual perceptions, namely, her own judgment of a patients' behavior.

The present study also provided more visible and specific criteria with regard to the type of patient behavior. The term "patients' behavior" was defined as specific types of patients' actions that encompass sexual connotations. Concrete examples independent from incidents of sexual harassment were included. Therefore, the objective occurrence of patients' behavior might be judged subjectively as sexual harassment for some nurses; however, some other nurses might not consider it as such.

Twelve female hospital nurses were interviewed to categorize the various forms of patients' behavior they experienced and to create questions for the questionnaire. Based on the results of the interview and previous studies (Çelik, & Çelik, 2007; Chaudhuri, 2007), eight categories were identified and assessed by two colleagues. The colleagues evaluated the wording of the questions, and the rate of concordance (kappa coefficient was 0.80). Regarding an unmatched item, its wording was revised several times, and finally both colleagues agreed on the last version. As a result, validity was confirmed. Cronbach's alpha coefficient was calculated using eight questionnaires; the result was 0.71, and reliability was evaluated.

Participants were asked whether they had encountered specific types of patient sexual behavior, classified into the following eight categories: sexual jokes and remarks; gazing at nurses with sexual interest; touching nurses' chest, hip, or elsewhere on the body; hugging; rape; requests for touching patient's body; requests for dates; and stalking. Respondents were instructed to answer, Yes, if they had at any time encountered any of these forms of a patient's behavior.

Instruments

Participants' demographic characteristics (age, marital status, and number of children) were obtained via questionnaires. For evaluation of the nurses' job duties and working environment, participants were asked how often they provided physical care to patients (very little, seldom, sometimes, often, or usually), how long they had been nurses, whether they held an administrative position (*Yes* or *No*), and the type of management (national, public, private, or other) present at their hospitals. For assessment of nurses' attitudes toward emotional care of patients, participants were asked how important (i.e., not important, less important, neutral, important, or very important) they considered empathy to be when dealing with patients. For assessment of nurses' attitudes toward gender equality, a shortened version of the "Scale of Egalitarian Sex Role Attitudes; SESRA-S" (Suzuki, 1991) was adopted. The scale consists of 15 statements, such as, "A mother who stays home and raises children is not the only ideal type of mother," and "Whether married or not, for purposes of independence, women should work," which are evaluated using a five-point Likert scale (from strongly agree to strongly disagree). Scores ranged from 15–75, and a higher total SESRA-S score indicates a more positive attitude toward gender equality. In a study reported by Suzuki (1991), the Cronbach's alpha coefficient for the SESRA-S scale was 0.91, and the test–retest correlation was 0.88 among study participants. In the present study, the participants' mean score on the SESRA-S was 54.68±6.96, and the Cronbach's alpha was 0.78, indicating adequate internal consistency.

Design and Procedure

In November 2004, based on the recommendation of the Ishikawa Prefectural Nurses Association, 600 questionnaires were sent to 60 hospitals in the Ishikawa Prefecture in north-central Japan. The number of questionnaires distributed (8–14 per institution) was determined according to the size of the institution. The director of the nursing department at each hospital was asked to distribute the questionnaires in a way that eliminated bias toward a participant's age. Each director was asked to distribute the same number of questionnaires to nurses from each age group. Questionnaires were returned by mail directly to the researchers by each respondent. Of the returned questionnaires, 9 were completed by male nurses and were excluded; 464 questionnaires were analyzed in this study (response rate 77.3%). This study conformed to the provisions of the Declaration of Helsinki in 1995 (as revised in Edinburgh, 2000) and was approved by an institutional review board.

Data Analysis

To clarify factors affecting the perceived incidence of sexual harassment and other sexual behavior, the data were analyzed using bivariate and multivariate analyses. Continuous variables were compared using the unpaired *t* test, and categorical variables were analyzed with the

Table 1. Association Between the Incidence of Sexual Harassment and Sexual Behavior (N=464)[a]

	Sexual harassment				Sexual behavior			
	+ (260)	− (180)	P for χ^2	R^b	+ (307)	−(157)	P for χ^2	R^b
Job title								
Assistant nurse (74)	31 (43.1)	42 (56.9)	<0.01	0.15**	37 (50.0)	37 (50.0)	<0.01	0.16**
Registereed nurse (376)	214 (62.4)	129 (37.6)			256 (69.9)	110 (30.1)		
Generation								
20–29 (115)	77 (68.1)	36 (31.9)	<0.05	−0.16**	83 (72.2)	32 (27.8)	<0.05	−0.11*
30–39 (128)	82 (66.1)	42 (33.9)			92 (71.9)	36 (28.1)		
40–49 (112)	50 (48.1)	54 (51.9)			68 (60.7)	44 (39.3)		
50–63 (104)	48 (51.1)	46 (48.9)			61 (58.7)	43 (41.3)		
Length of employment (year)								
0–10 (143)	92 (66.7)	46 (33.3)	<0.01	−0.14**	100 (69.9)	43 (30.1)	0.22	−0.06
11–20 (146)	89 (63.6)	51 (36.4)			102 (69.9)	44 (30.1)		
21–30 (128)	56 (47.5)	62 (52.5)			76 (59.4)	52 (40.6)		
31–40 (41)	20 (54.1)	17 (45.9)			27 (65.9)	14 (34.1)		
Administrative position								
Yes (141)	75 (59.1)	52 (40.9)	0.74	0.2	92 (65.2)	49 (34.8)	0.33	0.03
No (292)	172 (61.2)	109 (38.8)			200 (68.5)	92 (31.5)		
Marital status								
Married (304)	165 (57.0)	124 (43.0)	0.2	−0.07	200 (65.7)	104 (34.3)	0.32	−0.09**
Single (160) [c]	83 (64.3)	46 (35.7)			96 (71.1)	39 (28.9)		
Children								
More than one (161)	154 (55.2)	125 (44.8)	0.05	−0.1*	189 (63.4)	109 (36.6)	0.1	−0.08**
None (298)	102 (65.8)	53 (34.2)			115 (71.4)	46 (28.6)		
Management style	25 (51.0)	24 (49.0)			29 (56.9)	22 (43.1)		
National (51)	25 (51.0)	24 (49.0)	0.39	−0.005	29 (56.9)	22 (43.1)	0.28	0.007
Public (152)	90 (62.9)	53 (37.1)			105 (70.9)	43 (29.1)		
Private (182)	99 (61.1)	63 (38.9)			121 (68.4)	56 (31.6)		
Other (75)	40 (54.8)	33 (45.2)			48 (64.0)	27 (36.0)		
Physical care[d]								
(−) (50)	15 (41.6)	14 (48.3)	0.54	−0.04	16 (59.3)	11 (40.7)	0.41	−0.04
(+) (413)	232 (59.3)	159 (40.7)			277 (67.1)	136 (32.9)		
Understanding patients[e]								
(−) (72)	41 (60.3)	27 (39.7)	0.89	0.01	46 (63.9)	26 (36.1)	0.68	0.04
(+) (382)	213 (59.0)	148 (41.0)			256 (67.0)	126 (33.0)		
Gender role scale(SESRA-S)								
	55.73±6.98	53.23±6.37	<0.01[f]	0.19	55.40±7.17	53.26±6.30	<0.01[f]	0.16**

Note. [a]missing value excluded from the cross table; [b] spearman's correlation coefficient (**P<0.01, *P<0.05); [c]excluded divorced or widowed (n=25); [d](−); very few, seldom, sometimes, often. (+); usually; [e](−); important. (+); very important; [f]P for unpaired t-test.

chi-square test. A logistic regression model was used to calculate crude and adjusted odds ratios related to sexual harassment and behavior. Statistical analysis was performed using SPSS for Windows, version 14.0. A p-value<.05 was considered statistically significant.

Findings

Incidence of Sexual Harassment and Behavior

Of the 464 participants, 260 (56%) answered they had encountered sexual harassment at some time from patients, while 180 (38.7%) reported that they had never encountered sexual harassment, and 24 (5.2%) chose not to answer. Specific incidenctsof patientsexual behavior were as follows: sexual jokes and remarks were experienced by 298 (64.3%) nurses, physical contact by 277 (59.7%), gazing at nurses with sexual interest by 170 (36.7%), requests for dates by 126 (27.2%), requests for touching patient's body by 69 (14.8%), hugging by 65 (14.0%), stalking by 52 (9.8%), and rape by 4 (0.9%). In all, 307 (66.1%) participants reported some type of harassment from patients. The reported incidence of other behavior with sexual connotations was higher than the reported incidence of sexual harassment.

Table 2. Crude and Adjusted Odds Ratios From Linear Logistic Regression Model (*N*=464)

	Sexual harassment				Sexual behavior			
	Crude *OR* (95% *CI*)	*P*	Adjusted *OR* (95% *CI*)[a]	*P*	Crude *OR* (95% *CI*)	*P*	Adjusted *OR* (95% *CI*)[a]	*P*
Title								
Assistant nurse (74)	1.00		1.00		1.00		1.00	
Registereed nurse (376)	2.24 (1.34–3.75)	<0.01	1.75 (1.02–3.02)	<0.05	2.30 (1.38–3.84)	<0.01	2.03 (1.18–3.48)	<0.01
Administrative position								
Yes (141)	1.00		1.00		1.00		1.00	
No (292)	1.06 (0.82–1.36)	0.50	0.73 (0.45–1.19)	0.21	1.14 (0.74–1.75)	0.56	0.88 (0.54–1.42)	0.59
Marital status								
Married (304)	1.00		1.00		1.00		1.00	
Single (160) [b]	1.45 (0.94–2.25)	0.10	0.82 (0.47–1.44)	0.49	1.24 (0.79–1.94)	0.34	0.86 (0.49–1.52)	0.62
Child								
More than one (161)	1.00		1.00		1.00		1.00	
None (298)	1.66 (1.10–2.51)	0.02	1.03 (0.60–1.77)	0.90	1.40 (0.92–2.14)	0.11	0.99 (0.57–1.73)	0.98
Physical care[c]								
(−) (50)	1.00		1.00		1.00		1.00	
(+) (413)	1.39 (0.64–3.04)	0.41	1.08 (0.48–2.43)	0.84	1.44 (0.65–3.20)	0.37	1.21(0.53–2.75)	0.65
Understanding patients[d]								
(−) (72)	1.00		1.00		1.00		1.00	
(+) (382)	0.90 (0.54–1.51)	0.70	0.98 (0.58–1.67)	0.95	1.26 (0.76–2.09)	0.38	1.35 (0.81–2.28)	0.25

Note. [a]Adjusted for age, length of employment; [b]excluded divorced or widowed (n=25); [c](−); very few, seldom, sometimes, often. (+); usually; [d](−); important; (+); very important.

Sociodemographic Factors

Differences in age-group were observed using bivariate analysis with regard to both sexual harassment (p=.05) and other sexual behavior (p=.05; **Table 1**). In both cases, younger nurses—those in their 20s and 30s tended to report sexual harassment and other sexual behavior more frequently compared with middle-aged nurses age 40 and over. The variable called children was also significant for sexual harassment (p=.05) but not for other sexual behavior. Nurses with no children reported encountering sexual harassment more often than did nurses with children.

Job-Related Factors

The job title of the nurse was the most significant factor influencing both reports of sexual harassment (p<.01) and other sexual behavior (p<.01). In addition, the variable length of employment was significant for sexual harassment (p=.01), but not for other sexual behavior. Odds ratios calculated by multivariate analysis, adjusted for age and length of employment (**Table 2**), showed that the job title of the nurse remained significant with regard to sexual harassment (p=.04) and other sexual behavior (p=.01). Registered nurses were therefore at a much higher risk than were assistant nurses with regard to both sexual harassment and other sexual behavior.

Participants reported the frequency with which they provided physical care to patients as: very little (0.9%), seldom (1.5%), sometimes (2.9%), often (5.8%), and usually (89.0%). Most participants were involved in the physical care of patients in the daily clinical setting. The incidence of sexual harassment or other sexual behavior among participants who responded "usually" was compared with those who responded in the other categories. Frequency of physical care was not a significant factor for either sexual harassment or other sexual behavior. In addition, neither administrative position nor management style was a significant factor.

Attitudinal Factors of Nurses

Participants identified the importance of nurses conveying an attitude of empathic understanding toward patients as follows: not important (0%), less important (0%), neutral (1.5%), important (15.6%), and very important (82.9%). Most nurses, therefore, regarded empathic understanding of patients as important to most important. The incidence of sexual harassment or other sexual behavior among participants responding "important" was compared with those responding "very important." The results showed that empathic understanding was not a significant factor for either sexual harassment or other sexual behavior.

The gender role scale (SESRA-S) showed a statistically significant association with respect to sexual harassment ($p<.01$) and other sexual behavior ($p<.01$). Nurses having a positive attitude toward gender equality reported a higher incidence of sexual harassment and other sexual behavior. The job title held by the participant was statistically significant with regard to SESRA-S ($p<.001$, data not shown); that is, registered nurses had a more positive attitude toward gender equality than did assistant nurses.

Discussion

The results of the present study showed a higher incidence of specific types of patient behavior with sexual connotations than of sexual harassment. This phenomenon implies that the awareness of the nurses in this study toward sexual harassment was not sufficient. In other words, if nurses encountered some types of behavior from patients, some of them did not judge these actions as sexual harassment. This means that the incidence of sexual harassment might be underestimated. Another possible interpretation of this phenomenon is that underestimation of sexual harassment could be attributed to the tools adopted for the study, rather than the nurses' perception, as sexual harassment incidence was measured by only one item, while other sexual behavior was measured by eight items.

Nevertheless, many studies have indicated that, although nurses encounter some types of inappropriate patient behavior, for a variety of reasons, they hesitate to stop it or report it to their colleagues or supervisor to seek help or to take measures against it (Hibino, Inagaki, & Ogino, 2006). Overall, their reactions are moderate (Çelik & Çelik, 2007; Hibino, 2006). One reason is that nurses generally are afraid of hurting their patients (Kisa & Dziegielewski, 1996) and fear losing their jobs or being stigmatized (Chaudhuri, 2007). As a result, negative psychological effects (Chen, Hwu, Kung, Chiu, & Wang, 2008; Mckenna, Poole, Smith, & Coverdale, 2003) and degradation in the quality of care have occurred (Grieco, 1987; Lowell, 1999). The quality of nursing practice can be affected easily by sexual harassment, which means dealing with this problem and exploring the related factors is important.

The incidence of sexual harassment depends on an individual nurse's perception or judgment. On the other hand, the incidence of behavior with a sexual connotation is focused on a patient's visible action. The two concepts are similar but not identical; thus, in this study we assessed the incidence of both to compare the two and the factors associated with each.

One of the major factors affecting the reported incidence in this study was assumed to be the participant's age. The age-group variable was associated with the incidence of both sexual harassment and other sexual behavior, while the variables length of employment and number of children affected the incidence of sexual harassment but not other sexual behavior. These results indicated that the incidence of sexual harassment is affected by demographic characteristics more than the incidence of other sexual behavior. We also surmise that the demographic variables children or length of employment is mediated by participants' ages. For instance, the odds ratio adjusted for age and length of employment was calculated and the result showed no significance with regard to children in relation to sexual harassment. As a result, age is thought to be the strongest factor affecting the incidence of sexual harassment.

Moreover, age-group differences in the perception of sexual harassment indicate this concept might be better recognized by younger nurses (in their 20s and 30s) as compared to older nurses (40 and over). This phenomenon could, in part, be explained by the fact that the concept of sexual harassment was only recently introduced in Japan, and some middle-aged women do not believe in this as a concept. This might be one reason for the relatively large number of nonrespondents among middle-aged nurses (8.3%) compared to younger nurses (2.5%) with regard to sexual harassment ($p<.01$, data not shown).

One other important factor influencing the incidence of sexual harassment, in addition to that of age group, was thought to be job title. Namely, registered nurses were at much higher risk of sexual harassment and other sexual behavior than were assistant nurses, and this held true after the data were adjusted for participant age and length of employment. Thus, this relationship cannot be explained purely by age and length of employment. In Japanese hospitals, registered nurses are involved somewhat more in management duties than are assistant nurses, and therefore, in general, assistant nurses are thought to be more involved in bedside care, and possibly sexually harassed.

Therefore, this phenomenon might not be explained by the difference in job duty between registered and assistant nurses. One possible explanation for this result is that a person's attitude toward gender equality resulting from educational level might affect this relationship. Several studies have shown that nurses with higher educational levels are more likely to encounter sexual harassment (Çelik & Çelik, 2007; Fiedler & Hamby, 2000). A high educational level among registered nurses might enhance the perception of sexual harassment.

The responses obtained relative to the gender role scale (SESRA-S) showed that participants who had a positive attitude toward gender equality tended to be sexually harassed more often than were their counterparts, and they tended to encounter some types of sexual behavior. One possible explanation for this phenomenon might be female nurses, who have a positive attitude toward gender equality, tend to have a higher sensitivity toward patients' behavior, which violates human rights, and an assertive attitude against gender discrimination such as sexual harassment. Thus, nurses who have a positive attitude toward gender equality are more likely to recognize such behaviors and disapprove of them. In accordance with this explanation, some previous studies have proposed the perception of sexual harassment is dependent on a positive attitude toward gender equality (Fischer, Tokar, Good, Hill, & Blum, 2000; Juliette, Nicole, & Isis, 2007). This idea is supported by the present study, which found registered nurses had a much more positive attitude toward gender equality than did assistant nurses ($p<.01$), and they experienced sexual harassment and specific types of patient sexual behavior much more often than did assistant nurses.

This study has several limitations. The respondents were recruited from a limited geographical region in Japan, and no statistical sampling methods were performed. Thus, the findings do not represent the total population of female hospital nurses in Japan. Participants in the present study were limited to female nurses. The present study was a cross-sectional study, and thus, causal relationships cannot be determined from these results. Tools that are more reliable should be developed for assessing sexual harassment in future studies. Despite these limitations, the findings highlight some important issues that merit further discussion.

Conclusions

These results show that a positive attitude toward gender equality among nurses could be associated with an increased incidence of perceived sexual harassment and specific types of patient behavior that had sexual connotations. This is somewhat paradoxical. However, it can be suggested that lessons on gender equality should be included in nursing education and practice. To increase the awareness of sexual harassment among nurses, detailed guidelines, including a perspective on gender equality, should be provided to both practicing and student nurses. An increasing incidence of sexual harassment claims among nurses should prompt hospital organizations to take proper action against it. This study showed that a perspective on gender equality is needed for establishing a safer working environment, which would enable nurses to provide better care for patients, and thereby promote the development of a good relationship between nurses and patients in the long term.

Clinical Resources

- International Labor Organization: http://www.ilo.org/global/lang–en/index.htm
- International Council of Nurses: http://www.icn.ch/index.html
- Japanese Nursing Association: http://www.nurse.or.jp/jna/english/index.html

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