

Workplace discrimination and healthcare: The national EEOC ADA research project

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Abstract. Using the Integrated Mission System of the Equal Employment Opportunity Commission, the employment discrimination experience of Americans with disabilities within the Healthcare industry is explored. Specifically, the researchers examined discrimination allegations closed with and without merit associated with each of the nine Standard Identification Classification code healthcare service groups. Allegations made against skilled nursing, intermediate care, and personal care facilities, particularly those in the Southern region of the United States, were more likely to close with merit than those made against both hospitals and home health providers. Race predicted closure status with persons of mixed ethnic heritage, Asian Americans, and Native Americans most likely to have merit closures. The authors offer strategies for addressing discriminatory practices while providing opportunities for accommodations in an industry stressed by high turnover rates.

Keywords: Equal Opportunity Employment Commission, employment discrimination, workplace discrimination and healthcare

1. Introduction

The recruitment and retention of qualified workers in both professional and non-professional capacities is a significant challenge to the healthcare industry. A combination of forces including increased needs for technological competence, reimbursement issues, an aging population, and an aging workforce within the industry continues to drive the need for skilled, semi-skilled, and even unskilled labor. This issue is particularly critical in long-term care facilities faced with staff shortages and high turnover rates at a time when the demand for workers is on the rise [1,6,26]. Addressing controllable factors, such as increasing diversity in the workforce and decreasing discriminatory practices that could impact retention rates, remains an opportunity for vocational rehabilitation counselors as well as healthcare leaders and managers. The industry has a vested inter-

est in protecting the rights of persons with disabilities and proactively exploring avenues of opportunity for them.

The Equal Employment Opportunity Commission (EEOC) Americans with Disabilities Act (ADA) Research Project has completed two special issue journals. To date, none of the studies isolate significant differences between healthcare and other industries relative to disability type [16,32]. A review of the literature reveals that there is limited current research with regard to discrimination against persons with disabilities in the healthcare industry. One noted exception is an examination of the extent to which private hospitals are liable for discrimination against medical staff with disabilities under the Americans with Disability Act (ADA) [19]. The author concludes that the courts have applied the ADA in a manner broader than intended by Congress and private hospitals should assume these regulations apply to staff privilege decisions. A second exception is literature that addresses discrimination against HIV+ healthcare workers.

Given the shortage of existing research, this review focuses primarily on findings related to discrimination in healthcare regardless of disability status. Even with-

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in this body of knowledge, limited resources exist on the topic of discrimination within a wide range of health-care professions. Instead, the literature deals mainly with professionals rather than non-professionals, emphasizing nursing and academic medical personnel.

Recent literature offers some insight into the contemporary environment. A study completed by Harvard Medical School reveals that physicians experience discrimination most often based on gender, ethnicity/race, and international medical graduate status [8]. Ogden et al. [27], studying the attitudes of medical professionals regarding their understanding of what constitutes abuse, found that all agreed that racism, sexual harassment and belittlement were abusive behaviors. Yet, they also noted differences in perception as to the specific behaviors experienced as abusive. Attending physicians, for instance, were less apt to identify specific interactions as abusive when compared with members of other professions [27]. Studies such as this one speak to the challenge to reducing discrimination within the present industry context.

1.1. Age discrimination

A recent Lexis Nexus release indicates that one in four people aged 50–69 has experienced discrimination when working or looking for work despite the proven advantages of an age-diverse workforce. Discussing ageism in the medical profession in Great Britain, Forster [12] states that only 2% of medical students are over the age of 23, and that most schools would rather not recruit anyone over the age of 30. When staff reduction decisions are made, it is typically older workers who are encouraged to leave positions. Age discrimination is the result of an assumption that as persons age, their abilities decline. In reality, studies have shown that older workers are absent less, are more productive, and are more likely to remain in their positions [12].

In the United States, the average age of nurses is approximately 44 years old [20]. Letvak's study of older RNs and the connection between job satisfaction and job-related injuries revealed that nurses were more likely to experience an injury at work if they worked in a hospital setting, and had a high intensity job. Letvak recommends job accommodation and job redesign to take into account an aging nursing population as a strategy to retain valuable employees.

1.2. Race/ethnic discrimination

In a study describing types of discrimination experienced by physicians, and the physician group most likely to be discriminated against, Coombs and King [8] found that 44% of respondents reported discrimination against international medical students. Non-white physicians were more likely to report significant discrimination based on race or ethnicity.

Hagey [15], studying the experiences of immigrant nurses in the United States, found that all of the nurses who participated in the study had experienced difficulties in filing grievances against their employers. Mercer [24] studied nurse's aides in a nursing home setting and found that 77.7% of nurse's aides experienced the use of discriminatory language in the workplace.

Within the realm of academic medicine, Minicucci and Lewis [25] report that of the 80% of claims brought against institutions related to a change in status (dismissal, rejection, or demotion), over half involved accusations of discrimination. Of these claims, the most common were those related to race and national origin discrimination, followed by gender and sexual harassment. Most of these claims were found to be invalid because they were generally made after the individual had been removed, and there was no documentation of incidences of discrimination while on the job. Ninety percent of the cases presented in this study were won by the institution, though this number includes out of court settlements [25].

Within the nursing profession, Staten et al. [28] report that 80% of nurses between the ages of 22 and 34 will change jobs in the next two years. In attempting to find ways of retaining quality nurses, this study reviews the job attributes of perceived managerial control, role clarity and innovation. Nurses in the Hispanic population were more likely to perceive managers as overly controlling. Overall, the Caucasian group experienced the lowest amount of managerial control over their work, thus leading to higher job satisfaction in their current position [28].

1.3. Gender discrimination and sexual harassment

Based on findings by Western Carolina University, comparing a 2001 study to a 1994 study, sexual harassment may actually be on the rise in hospital settings with the majority of complainants being female and employed as nurses with the majority of all complaints being against physicians [18]. It appears that the larger medical practices are more prone to being sued for dis-

crimination and sexual harassment by their employees. In those larger practices there is more to be gained for the plaintiff because the suit goes against not only the defendant but against all within the practice [13].

In a 1994 study, Kaye and Merker [17] found that 46% of nurses responding to their survey had experienced sexual harassment in the workplace. A majority of the incidents of harassment were not reported. Kinard and Little [18], in their 2002 survey, found that claims of sexual harassment had increased and that nurses were the most likely to file charges. "Of the 200 cases that were resolved, 77.5% were judged to be with merit, whereas 22.5% were judged to be without merit" [18]. In a study of 188 nurses, Valente and Bulough [29] found that almost half experienced sexual harassment, but most had not reported these incidents.

Within the realm of academic medicine, Carr et al. [4, 5] report that almost half of the women in academic medicine experience gender discrimination and sexual harassment, claiming that this is a primary reason for the lack of advancement in their careers. This supports previous studies of women within Radiology [9] and Cardiothoracic Surgery [11]. McGuire [21] states that there is a strong perception of gender discrimination that prevents women from entering the field of medicine.

Anthony [2] offers a different perspective on gender discrimination in nursing by discussing the difficulty of male nurses within the profession. Anthony reviews the current research on the experiences of male nurses, and finds that most nursing programs do not take into account the different learning styles of men and the particular stressors experienced by male nursing students. Male nurses also report additional expectations of having to assist with any heavy lifting and transporting of patients [2].

1.4. Healthcare discrimination and HIV status

The early to mid-1990's produced a body of literature regarding the transmission of HIV disease from healthcare providers to patients. This led to the guidelines by the Centers for Disease Control (CDC) promoting the use of Universal Precautions as well as expert panels to review risks associated with HIV providers prior to engaging in exposure-prone procedures [10,14]. CDC Guidelines did not support the public call for mandatory testing of healthcare workers leading instead to the development of state regulations. As states implemented guidelines, a range of restrictions were imposed, from limited restrictions in states such as New York and

Michigan to more restricted regulations in states such as Illinois and Minnesota. Consistent among the states was development of a model that advocates protection of confidentiality rights for health care practitioners while ensuring public safety [10].

As might be anticipated, a number of court cases emerged during this period of time. The discrimination claims by HIV+ healthcare workers tended to relate to dismissal or practice limitations. The courts have rather consistently held that reasonable accommodations, to include non-direct patient care or non-invasive care activities, by employers for practitioners are legal [30, 31]. However, according to Burris [3], the legal system has not developed a consistent standard for practice guidelines with this group of healthcare workers. As such, an opportunity for healthcare to set its own standards and develop socially responsible, non-restrictive policy remains open. Responding to this opportunity remains critical for healthcare, as with other industries, as the EEOC ADA Research Study has demonstrated significantly higher rates of merit resolutions for HIV+ persons than those in the general database [7].

2. Methods

Data for this study were taken from the EEOC Integrated Mission System (IMS) dataset (MOTHER). This data represents all ADA Title I allegations of employment discrimination made to the EEOC from the effective date of ADA (July 26, 1992) through September 30, 2003. All allegations were included, including those based upon disability, the history of disability, or the perception or association of disability. The only definitional extraction involved allegations based upon association of persons with disabilities, as such persons were not themselves disabled. Only allegations investigated and closed by the EEOC were included in the present analysis; allegations still under investigation were excluded. This allows for a clearer understanding of actual discrimination in the workplace because closures provide a clear distinction regarding whether with resolutions have merit (discrimination was determined by the EEOC to have occurred) or are without merit (insufficient evidence of discrimination was determined by the EEOC).

The IMS data covers all industries and employment types which are detailed by means of a Standard Industrial Classification (SIC code). Those SIC codes from 801 to 809, noting healthcare services, were extracted for the current study. This resulted in nine groups

Table 1
Closure Codes and Frequencies for 174,610 GENDIS Allegations from Persons w/Physical, Sensory or Neurological Impairments

Type of Closure	N	DEFINITION	MERIT
Withdrawn w/CP Benefits	10,726	Withdrawn after independent settlement, resolved through grievance procedure, or after Respondent unilaterally granted benefits w/o formal "agreement".	YES
Settled w/CP Benefits	14,603	Settled and EEOC was involved in settlement.	YES
Successful Conciliation	4,378	EEOC has determined discrimination occurred, and Respondent has accepted resolution.	YES
Conciliation Failure	8,707	EEOC has determined discrimination occurred, but Respondent has not accepted resolution.	YES
No Cause Finding	115,403	Full EEOC investigation failed to support alleged violation(s).	NO
Admin Closure	2,066	Due to processing problems; e.g., Respondent out of business or cannot be located, file lost or cannot be reconstructed.	NO
Admin Closure	102	Due to Respondent bankruptcy	NO
Admin Closure	537	Because CP cannot be located	NO
Admin Closure	1,690	Because CP non-responsive	NO
Admin Closure	2,596	Because CP uncooperative	NO
Admin Closure	138	Due to outcome of related litigation	NO
Admin Closure	70	Because CP failed to accept full relief	NO
Admin Closure	10,746	Because EEOC lacks jurisdiction; includes inability of CP to meet definitions, Respondent <15 workers, etc.	NO
Admin Closure	2,848	Because CP withdraws w/o settlement or benefits. Reason unknown	NO

of healthcare services grouped according to SIC code group as follows: offices and clinics of medical doctors ($n = 3,079$); offices and clinics of dentists ($n = 148$); offices and clinics of osteopathic physicians ($n = 19$); offices and clinics of chiropractors, optometrists, podiatrists, and health practitioners ($n = 392$); skilled nursing, intermediate care, and nursing and personal care facilities ($n = 4,737$); general medical/surgical, psychiatric, and specialty hospitals ($n = 14,078$); medical and dental laboratories ($n = 1,020$); home healthcare services ($n = 856$); and kidney dialysis centers, specialty outpatient clinics, and health and allied services ($n = 2,922$). The resulting dataset specific to this study included a total of 27,251 allegations that were received, investigated and closed by the EEOC.

Consistent with the demographics of the healthcare workforce (approximately 77%), the majority of the allegations were made by female charging parties (74%). Charging parties reflected the breadth of the cultural/ethnic make-up of the nation and consisted of Anglos (16,842), African Americans (5,870), Hispanics (1,472), Asian Americans (385), Native Americans (169), and persons of mixed ethnic heritage [17]. Additionally, 2,200 charging parties were coded by the EEOC as "other" and the ethnic/cultural background of 296 parties were unknown. Mean age of all Charging Parties was 27.46 years and the median age was 44 years. Allegations were made from each of the four Census Bureau regions (South = 11,027, Midwest = 8,180, West = 4,496, North = 3,529) and U.S. territories [19].

2.1. Data analysis plan

The data for this study were analyzed in the following ways. First, two analyses of variance (ANOVAs) were conducted to determine if differences existed [1] in the discrimination issue alleged (i.e., the type of discrimination) and [2] the types of closure (i.e., with or without merit) associated with each of the nine SIC code healthcare service groups. To aid in interpretation of the second ANOVA, closure status was collapsed into two categories: closed with merit (closure codes M1, M2, M4, and M5) and closed without merit (closure codes M3, X2-X8, and Y1-Y2).

Effect sizes and 95% confidence intervals (95% CI) were also calculated for each of these ANOVAs. Second, post hoc examinations were conducted, using a Bonferroni control for Type I error, in order to determine precisely which healthcare industries differed. Finally, multiple regression analyses were conducted using sex, age, and ethnicity of the Charging Parties as predictor variables and case closure status (with or without merit) as the criterion variable.

2.2. Results

The first ANOVA conducted to determine if there were differences in the types of allegations made with regard to the nine healthcare service subgroups was not significant [$F(9, 27241) = 1.42, n.s.; 95\% \text{ CI} = 19.80, 20.13$] indicating that the various forms of alleged discrimination were comparable across each of the respective groups. The second ANOVA was significant [$F(9,$

Table 2
Standardized Regression Weights and Confidence Intervals

	Standardized β	95% Confidence Interval
Sex	−0.008	−0.019, 0.004
Ethnicity*	0.014	0.001, 0.004
Age**	−0.018	−0.002, −0.001

Note: * = $p < 0.05$; ** = $p < 0.01$.

27241) = 3.42, $p < 0.001$; 95% CI = 0.21, 0.23], indicating that closure status differed with regard to particular healthcare service groups. Post hoc examination noted two significant differences. Allegations made against skilled nursing, intermediate care, and personal care facilities were more likely to be closed with merit than those made against both hospitals ($p < 0.01$) and home health care providers ($p < 0.05$).

Results of the multiple regression analysis noted two significant predictors of closure status. Race of the Charging Parties predicted closure status, with persons of mixed ethnic heritage, Asian Americans, and Native Americans more likely to have merit closures than Anglos, African Americans, Hispanics, or “others”. The age of charging parties also predicted closure status, with younger Charging Parties more likely to have merit closures than older Charging Parties. The standardized coefficients and 95% confidence intervals these regression analyses may be found in Table 2.

Within the ethnic groups noted above some proportional differences are noted relative to discrimination type. Discharge (36% v. 31.6%) and Harassment (12.4% v. 7.8%) are higher for Native Americans than for MOTHER. In the population of allegations by Asian Americans, Harassment (10.9% v. 7.8%), Terms/Conditions of Employment (10.9% v. 8.6%) and Reasonable Accommodation (20.8% v. 17.7%) are disproportionately higher than MOTHER.

3. Discussion

While the existing literature offers limited insight into understanding the results of the data, the results reveal some factors of interest. The fact that allegations against nursing and personal care facilities closed with greater merit than against hospitals may suggest that human resource departments in hospitals have more knowledge and understanding of workplace discrimination relative to persons with disabilities. Technical Standards for job performance are now commonplace in hospitals. These standards identify upon hire the bona fide occupational qualifications that incorporate

the physical, cognitive, and emotional requirements for individual positions.

Inherent distinctions between hospitals and nursing facilities may help to explain the difference in merit resolutions. The organizational structure of hospitals tends to be more comprehensive with chief executive and operating officers as well as various levels of human resource specialists. Orientation that includes sensitivity to diversity issues and expectations of cultural competence are commonplace in hospitals. The organizational structure of nursing care facilities tends to be more flat with fewer resources devoted to human resource matters thus limiting the corporate knowledge base.

Hospitals employ a higher percentage of professional positions than do nursing home facilities. Restorative options are more available for professionals, especially in the areas of substance abuse and HIV+ status. Employing individuals with a higher level of technical skills including those who are technologically literate, hospitals have a broader range of employment options that allow for reasonable accommodations.

At first glance, the finding that younger Charging Parties are more likely to have merit closure than older Charging Parties appears inconsistent with the common wisdom that discrimination is more apt to impact older adults. However, younger healthcare workers may in fact be more sophisticated in understanding their rights regarding disability status. Younger workers have grown up in the ADA age and may be more aware of their rights to options such as reasonable accommodation. Older persons with disabilities who served in healthcare prior to 1990 and who may not have had the benefit of ADA protection are more likely to have either left the industry or already made their own accommodations within it. Additionally, older workers have other grievance options and may be more apt to see discrimination related to age or gender rather than disability status.

When looking at race and closure status with merit one observes that Asian American ethnic background has connection to the literature. Discrimination against International healthcare workers in the general population most likely carries over to the population of healthcare workers with identifiable disabilities. The high rate of merit resolutions for Asian Americans is a point of particular interest. This may be attributed to cultural factors as Asian Americans were less likely to file formal complaints [33]. It is more likely therefore that the discrimination was of a more grievous nature explaining their higher instance of merit.

It is difficult to draw much conclusion about the high rate of merit resolutions for Native Americans since the n, 169 of 27,251, allegations is so small. However, there may be reason to suspect that actual discrimination of Native Americans with disabilities may be proportionately more prevalent in healthcare as it is lower (17.4% v. 19.9%) than in the MOTHER [22].

A factor of interest is that Harassment is disproportionately higher among both Asian Americans and Native Americans. Harassment of non-white health care workers is well documented in the literature. It comes as little surprise that this would be extended to persons with disabilities.

A final result of note is the disproportionately high number of allegations coming from the Census Bureau's South region and the low number from the North region. The likely explanation is alternative avenues for seeking resolution. In particular, union representation in healthcare is disproportionately more prevalent in the North than the South [34].

4. Conclusion and recommendations

These findings suggest opportunities for reducing workforce discrimination within healthcare for persons with disabilities. Vocational rehabilitation professionals and advocates as well as human resources professionals will want to develop strategies to resolve this issue while targeting nursing and personal care facilities in the South, particularly those who may employ higher percentages of Native American and Asian American workers.

Healthcare organizations will want to develop management strategies that address both existing discriminatory practices and disability accommodations for healthcare workers with a qualified disability. At one level, organizations need to develop strategies that promote an environment committed to respect for diversity- racial/ethnic, gender, disability. Common strategies such as diversity training and development of cultural competence that is inclusive of all areas affected by discrimination will require development. This is particularly important when it comes to Asian Americans and Native Americans whose allegations based upon Harassment are proportionately higher than MOTHER. Institutional policies regarding review, promotion, and dismissal will need to be enforced evenly. Workplace accommodations that demonstrate creativity in environmental planning as well as the development of strategies such as the use of adaptive technology

will want to be promoted by both management and rehabilitation professionals.

New and creative programs to promote the hiring of persons with disabilities and their opportunities for advancement can assist healthcare organizations who will continue to face worker shortages in the next decade. Programs at Cincinnati Children's Hospital Medical Center and Fred Hutchinson Cancer Research Center are two programs recognized for such efforts [23]. Organizations will also want to listen for recommendations from the workforce for specific strategies designed to address discriminatory actions by colleagues. Such practices suggest specific benefit to nursing homes and long-term care facilities where an open administrative climate can positively impact turnover rates [1].

References

- [1] R. Anderson, K. Corazzini and R. McDonald, Complexity science and the dynamics of climate and communication, *The Gerontologist* **44** (2004), 378–388.
- [2] A. Anthony, Gender bias and discrimination in nursing education: can we change it? *Nurse Educator* **29** (2004), 121–125.
- [3] S. Burris, Human immunodeficiency virus-infected health care workers: the restoration of professional authority, *Archives of Family Medicine* **5** (1996), 102–106.
- [4] P. Carr, L. Szalacha, R. Barnett, C. Caswell and T. Inui, A ton of feathers: gender discrimination in academic medical careers and how to manage it, *Journal of Women's Health* **12** (2003), 1009–1018.
- [5] P. Carr, A. Ash, R. Friedman, L. Szalacha, R. Barnett, A. Palepu and M. Moskowitz, Faculty perceptions of gender discrimination and sexual harassment in academic medicine, *Annals of Internal Medicine* **132** (2000), 889–896.
- [6] N. Castle and J. Engberg, Organizational characteristics associated with staff turnover in nursing homes, *The Gerontologist* **46** (2006), 62–73.
- [7] L. Conyers, K. Boomer and B. McMahon, Workplace discrimination and HIV/AIDS: The national EEOC ADA research project, *WORK* **25** (2005), 37–48.
- [8] A. Coombs and R. King, Workplace discrimination: experiences of practicing physicians, *Journal of the National Medical Association* **97** (2005), 467–477.
- [9] C. Deitch, J. Sunshine, W. Chan and K. Shaffer, Women in the radiology profession: data from a 1995 national survey, *American Journal of Radiology* **170** (1998), 263–270.
- [10] S. DiMaggio, State regulations and the HIV-positive health care professional: a response to a problem that does not exist, *American Journal of Law and Medicine* **19** (1993), 497–522.
- [11] C. Dresler, D. Padgett, S. MacKinnon and G. Patterson, Experiences of women in cardiothoracic surgery. A gender comparison, *Archives of Surgery* **131** (1996), 1128–1135.
- [12] P. Forster, The fortysomething barrier: medicine and age discrimination, *British Medical Journal* **306** (1993), 637–639.
- [13] M. Goldberg, It's getting easier for employees to sue you, *Medical Economics* **74** (1997), 91–97.

- [14] L. Gostin, A proposed national policy on health care workers living with HIV/AIDS and other blood-borne pathogens, *Journal of American Medical Association* **284** (2000), 1965–1970.
- [15] R. Hagey, Immigrant nurses' experience of racism, *Journal of Nursing Scholarship* **33** (2001), 389–394.
- [16] *Journal of Vocational Rehabilitation* **23** (2005).
- [17] J. Kaye, C. Donald and S. Merker, Sexual harassment of critical care nurses: a costly workplace issue, *American Journal of Critical Care* **3** (1994), 409–415.
- [18] J. Kinard and B. Little, Sexual harassment in the health care industry: a follow up inquiry, *The Health Care Manager* **20** (2002), 46–52.
- [19] L. LaConte, Managing medical staff disability issues: liability of private hospitals under ADA Titles I and III, *Journal of Health Law* **34** (2001), 67–103.
- [20] S. Letvak, Health and safety of older nurses, *Nursing Outlook* **53** (2005), 66–72.
- [21] L. McGuire, M. Bergen and M. Polan, Career advancement for women faculty in a US school of medicine: perceived needs, *Academic Medicine* **79** (2004), 319–325.
- [22] B. McMahon and F. Chan, Drivers of workplace discrimination involving Native Americans with disabilities: The US EEOC ADA research project (Unpublished).
- [23] B. McMahon, P. Wehman, V. Brock, R. Habock, H. Greene and R. Fraser, Business, disability and employment: corporate models of success <http://www.worksupport.com/research/viewContent.cfm/42>, 2005.
- [24] S. Mercer, Nurse's aides in nursing homes: perceptions of training, work loads, racism, and abuse issues, *Journal of Gerontological Social Work* **21** (1993), 95–112.
- [25] R. Minicucci and B. Lewis, Trouble in academia: ten years of litigation in medical education, *Academic Medicine* **78** (2003), S13–S15.
- [26] R. Montgomery, L. Holley, J. Deichert and K. Kosloski, A profile of home care workers from the 2000 census: how it changes what we know, *The Gerontologist* **45** (2005), 593–600.
- [27] P. Ogden, E. Wu, M. Elnicki, M. Battistone, L. Cleary, M. Fagan, E. Friedman, P. Gliatto, H. Harrell, M. Jennings, C. Ledford, A. Mechaber, M. Mintz, K. O'Brien, M. Thomas and R. Wong, Do attending physicians, nurses, residents and medical students agree on what constitutes medical student abuse? *Academic Medicine* **80** (2005), S80–S83.
- [28] D. Staten, M. Mangalindan, C. Saylor and D. Stuenkel, Staff nurse perceptions of the work environment: a comparison among ethnic backgrounds, *Journal of Nursing Care* **18** (2003), 202–208.
- [29] S. Valente and V. Bullough, Sexual harassment of nurses in the workplace, *Journal of Nursing Care* **19** (2003), 234–241.
- [30] Estate of Behinger v. Medical Center at Princeton, *Atlantic Report* **592** (1991), 1251–1284.
- [31] Mauro v. Borgess Medical Center, *Federal Supplement* **886** (1995), 1349–1356.
- [32] *WORK* **25**(1) (2005).
- [33] <http://www.census.gov/prod/2004pubs/censr-17.pdf> Asian Americans represent 4.1% of the US population but only 1.2% of allegations in MOTHER.
- [34] US Department of Labor Statistics (2007). Union Membership News Release, 2006 Union affiliation of employed wage and salary workers by state. Washington, DC: US Department of Labor.