

VIEWPOINT

VOICES IN CARDIOLOGY

Sexual Harassment, Victim Blaming, and the Potential Impact on Women in Cardiology



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*“[Examples of sexual harassment are] so many it
is impossible to start—I believe this is endemic in
cardiology/cardiothoracic [surgery] as it is in the
film industry—I really mean this.”*

—Anonymous woman in cardiology from a survey (1)

SEXUAL HARASSMENT

Sexual harassment is a global issue. It is widespread among age groups, races, genders, cultures, political beliefs, religions, and diverse workplaces. After a thorough review of the social scientific and legal literature, the National Academies of Sciences, Engineering, and Medicine (NASEM) defined sexual harassment as involving 3 components: gender harassment, unwanted sexual attention, and sexual coercion (2). Gender harassment is the most common type of sexual harassment. It refers to a broad range of verbal and nonverbal behaviors that convey hostility, objectification, exclusion, and degrading attitude towards members of 1 gender. Unwanted sexual attention entails unwelcome verbal or physical sexual

advances without any professional rewards. Sexual coercion entails sexual advances with status or employment benefits conditioned on sexual favors (2). A meta-analysis focusing on sexual harassment in the workplace has shown that the prevalence of sexual harassment in U.S. academia is 58%, second only to the military at 69%, and outpaces that of government and industry settings (3). The prevalence of sexual harassment in academic medicine is almost double that of other science and engineering specialties, with nearly one-half of all trainees at surveyed institutions reporting harassment from faculty or staff (2).

The NASEM provides extensive published data on how women working in male-dominated fields, compared with gender-balanced workgroups and workgroups with significant power differentials within hierarchical organizations, experience more frequent sexual harassment (2). The Accreditation Council for Graduate Medical Education general cardiology fellowship training was ranked first amongst medical subspecialties for the under-representation of women, with only 25% women in 2019 to 2020 (4). Women are under-represented in cardiology, making it challenging for female trainees to seek advice, support, and mentorship from established women cardiologists; even within the cardiology subspecialties, there is a greater gender divide and potential for increased discrimination and harassment (5). The hierarchical structure of medicine with evident power differential in academic medicine can lead to misuse of power and sexual harassment (2). However, sexual harassment is perhaps more pervasive and not limited to academic medicine alone.

Sexual harassment disproportionately affects women. A survey conducted in the United Kingdom by 174 cardiologists showed 35.7% of female cardiologists

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had some unwanted sexual harassment from a superior or colleague compared with 6.1% of male cardiologists (1). In a United States study of 1,066 recipients receiving the National Institutes of Health K-awards in 2006 to 2009, 30% of women experienced sexual harassment compared with 4% men (6). Another survey of full-time U.S. academic medical school faculty reported 52% of the female faculty being sexually harassed in the workplace, compared with only 5% male faculty (7). A cross-sectional survey of female physicians with active Louisiana licenses disclosed 96% of participants experienced gender harassment from colleagues, 69% experienced unwanted sexual attention from those colleagues, and 38% reported having experienced at least 1 inappropriate sexual incident in their career (8).

Most of these incidences are under-reported due to feelings that they will not be helped, are unworthy of help, will not be protected from their assailant, and could cause psychological harm. Lack of formal mechanisms to report or ineffective measures to handle reporting can contribute to under-reporting (9). Only 1 of 5 rape survivors receives medicolegal services; at the same time, one-half of sexual assault victims get support from informal sources (10). A study done on vascular surgery faculty across 52 American training sites found that although 84% of respondents acknowledged known institutional reporting mechanisms, only 7.2% of the harassing behaviors were reported. This low reporting was due to fear of repercussions (30%) or feeling uncomfortable disclosing it to the leadership (59%) (11).

VICTIM BLAMING

One of the barriers in reporting sexual harassment is the pervasive nature of victim blaming (VB). VB is defined as “someone saying, implying, or treating a person who has experienced harmful or abusive behavior like it was a result of something they did or said, instead of placing the responsibility where it belongs: on the person who harmed them” (12).

BASIS OF VB

The psychological basis of VB relies on 3 major theories involving the victim’s devaluation for various reasons (13). The “just world hypothesis” states that people distance themselves from the victim because they believe the world is “just” and people get what they “deserve” rather than accepting that those terrible things happen for no reason (14). It is much easier to shame someone into what they “should” have done in a situation where the outcome is already known (15). People like to distance themselves from

an unpleasant occurrence and perhaps confirm their hesitation to the risk of that particular occurrence happening to them, especially when the victims are not significantly different from them (“psychological distancing theory”) (13). Where this theory intersects with gender is not fully known; however, when the perception and stereotype of a working woman versus a housewife were investigated, the working woman was negatively perceived for her “nontraditional” role in society. The working woman’s perceived lack of warmth is more worthy of blame than the “traditional” housewife (16). Implicit biases are at the core of VB. Often the sexual harassment is linked to what the victim was wearing, actions, being in the wrong place, or an outgoing personality, which deviates emphasis from the abuser to the survivor (“attribution theory”) (13). Because implicit biases rely on one’s own experience, moral judgment, and cultural beliefs, blaming the survivor perpetuates the VB societal culture. The impact of the attitude toward victims has been tied to individuals with specific “moral values”—“binding” moral values like loyalty, authority, and purity have been associated with victim derogation and blame.

On the other hand, those who had more “individualizing” values viewed the victim as “injured” and focused more on preventing harm to the victim (17). Sexist attitudes have been associated with sexual harassment myths. In an Italian study, students with increased hostility toward women (higher in men), a more negative view of the female gender, and benevolence toward men (higher in men) believed in rape myths disproportionately more than the students who did not have such sexist viewpoints (18). It is crucial to be aware of such myths and our own implicit bias surrounding sexual harassment scenarios to deconstruct what really happened.

CONSEQUENCES OF SEXUAL HARASSMENT AND VB

The VB attitude marginalizes the survivor and makes it difficult for the victim to come forward and report the problem. Sexual harassment and VB can have a negative impact on the psychological and physical health of the survivors. This negative impact can include mental health impact (post-traumatic stress disorder, anxiety, depression), inability to focus and work at full potential, burnout, poor self-esteem, career setback, and fear of being seen as a troublemaker (1,2,6,19,20).

Sexual harassment affected professional confidence in 38% of female cardiologists versus 10.6% of male cardiologists in a U.K. survey. One-third of

the female cardiologists felt that sexual harassment reduced opportunities for professional advancement (1). In another study, 60% of the U.S. women physicians who reported sexual harassment said it had a negative effect on their confidence in themselves as professionals, and 50% said the experiences negatively affected their career advancement (6). A Danish study found that employees who are sexually harassed by supervisors, colleagues, or subordinates may develop more severe symptoms of depression than those who are harassed by clients or customers (19). Even nonphysical sexual harassment such as derogatory comments, unwanted sexual attention, and unsolicited explicit images can take a psychological toll, potentially exacerbating anxiety, depression, negative body image, and low self-esteem (20).

SOLUTIONS

Solutions to the problem of sexual harassment can start with women in cardiology identifying our own implicit biases in such cases. We can challenge the VB culture by believing the survivors, letting them know it is not their fault, reporting incidents when they occur, and not making excuses for an abuser's actions. Drs. Niemi and Young demonstrated that altering the language while speaking and changing the focus from the victim to the perpetrator significantly took the blame off of victims (17). Within medicine, it is paramount that the institutional leaders, if not everyone, obtain implicit bias training to appreciate how stereotypes and attitudes can influence the professional response to and an investigation of sexual harassment. NASEM defines a roadmap to end sexual harassment and hostility women face in medicine by outlining the need for significant changes by reducing organizational hierarchies, increasing women in leadership, shifting to mentor networks, and awarding grants to departments instead of individuals (2,21). Diffuse power structures, a culture of transparency and accountability, strict

implementation of sexual harassment policies and disciplinary consequences, and development of support systems for victims can help change the organizational climate and decrease the incidence of sexual harassment for either gender. Being the only woman at the table makes it challenging to address inappropriate behaviors. NASEM recommends bystander training to practice how to intervene in such situations (21). Although there are multiple shared experiences of sexual harassment amongst Women in Cardiology discussed behind closed doors, this has not been systematically studied. This paper should act as a call to action for further research to investigate sexual harassment in cardiology and provide the framework to address this problem.

CONCLUSIONS

Sexual harassment in cardiology is not uncommon. As a community, we need to foster a safe working environment, promote diversity and inclusion in organizational leadership, and collectively be aware of VB as a barrier to ending perpetuating the VB culture and sexual harassment.

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