ORIGINAL RESEARCH

"Not a Woman-Question, But a Power-Question"

A Qualitative Study of Third Parties on Psychological Violence in Academic Medicine

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Abstract: *Background:* Psychological violence is a persistent issue in academic medicine and affects the health and safety of health care workers. This violence is also debated as part of medical culture. Third parties, persons learning about violations after it happened, may provide an understanding of the interplay between gender and psychological violence. Perspectives on research on psychological violence in academic medicine are currently lacking. *Methods*: In this qualitative exploratory study, interviews were conducted with women from a working group on equal treatment at one medical university in Austria. This group monitors discrimination and harassment and consists of medical doctors, natural scientists, administrative staff, and students. To recruit participants, an email invitation was sent to members of the working group. Of 20 eligible persons, 12 women participated. After written consent from participants, individual interviews were conducted face-to-face, audio-recorded, and transcribed verbatim. Data were analyzed with grounded theory. *Findings*: Participants described a firm organizational culture with persistent, historically grown gendered structures. Potential threat of psychological violence affected mostly "weaker," less powerful persons, and often women. Descriptions of violence indicated harm to those affected, but intent to harm was doubted. Interventions strengthened the individual, but some participants demanded collective responsibility. *Conclusion/application to practice*: Few descriptions could be classified as psychological violence. Findings indicated a need to change organizational cultures where lower positions pose a potential threat to experiencing harm. Occupational health practice should include training in sensitization to psychological violence, protection of those targeted, deconstructing power accumulation, and promoting diversity in career patterns and working styles.

Keywords: psychological violence in the workplace, power, gender, academic medicine

Background

Internationally, demands have been made for psychological violence in the medical working environment to be eradicated (Bates et al., 2018). Hence, it is necessary to understand psychological violence and the mechanisms preserving it. Psychological violence has been defined as "[a]ny intentional conduct that seriously impairs another person's psychological integrity through coercion or threats" (European Institute for Gender Equality, 2020). Similarly, in her conceptual paper, Hamby (2017) defined violence as "nonessential, unwanted, intentional, and harmful behavior" (p. 177).

In the workplace, psychological violence can manifest itself as, for example, assault, harassment, bullying, incivility, or microaggression (Escribano et al., 2019; Hershcovis, 2011; Sue, 2010). In a survey of 606 medical doctors (medical specialists, junior doctors and resident physicians), participants reported rude, dismissive, and aggressive communication, especially by those who had lower status or were lower in hierarchy (Bradley et al., 2015). Thus, 18% of 276 medical specialists experienced such communication as compared with 43% of 194 junior doctors and 38% of 136 resident physicians (Bradley et al., 2015). However, the authors did not report on gender. In an interview study involving 50 medical doctors (29 women), anger, fear, and intimidation were perceived as training instruments used by women and men (Crowe et al., 2017). This resulted in feelings of alienation, distress, and disillusionment. In a survey of 705 physicians, 82.5% of women and 65.1% of men reported at least one incident of sexual harassment (e.g., unwanted sexual attention) from institutional insiders such as staff or students (Vargas et al., 2020). Frequent experiences with sexual harassment negatively influenced participants' mental health, job satisfaction, or feeling safe at work, but seniority was connected to better mental health and increased job satisfaction.

Such studies warrant a discussion of organizational culture in academic medicine, which is defined by shared assumptions, values, beliefs, and practices (Braithwaite et al., 2017). From their literature review, Scott et al. (2003) concluded that such culture is reproduced by social interaction of its members and

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Applying Research to Occupational Health Practice

Psychological violence in medicine appears to be widespread and is repeatedly the subject of various studies in occupational health. This study investigated third parties and their perception of psychological violence in medicine. Hamby's (2017) characteristics of violence—intent, harm, and acts being nonessential and unwanted—are promising as a means of defining psychological violence in the workplace. Occupational health practice should be aware of power in this context: Conflation of gender and power has to be considered as there might still be disadvantages for women in masculinized/gendered structures of medicine. Intent might be doubted, but should be seen in the context of harm; denying intent can be used as an instrument of power. Organizational culture might be slowing down change in medicine and health care. Emancipation and empowerment on a societal level are diametrically opposed to a mostly outdated traditional system resisting such change.

by structures being affirmed over long periods of time. In a literature review on barriers and facilitators in female surgeons' careers, Hirayama and Fernando (2018) deduced that the organizational culture included rigid structures that favored men over women. In their meta-analysis of workplace mistreatment, McCord et al. (2018) assumed that experiencing and reporting mistreatment was connected to power structures and job status. Women in "follower" positions may be subordinated by their gender, as well as their (often lower) job status (McCord et al., 2018). Similarly, an analysis of 315 narratives on workplace inclusion in hospitals and medical schools showed that inequality and discrimination were commonly described as benefiting "white old boys clubs" (Aysola et al., 2018).

In a qualitative study involving 50 junior medical doctors (29 women, 21 men), participants learned to accept strict medical hierarchy (Crowe et al., 2017). This hierarchy was portrayed with regard to power differences in job status (e.g., junior vs. senior) and non-questioning of judgment of senior staff. Fear of retaliation or consequences for their career were reported as reasons for non-reporting of mistreatment.

Bystanders and third parties may provide another perspective on the phenomenon of psychological violence in the workplace. Katz (2018) defined bystanders as "members of peer cultures, who share a sense of responsibility for others within immediate and extended communities" (p. 1763). Bystander's responsibility also extends to the aftermath of such violations, thus how the person is treated after the violation or after reporting the violation (Katz, 2018). In this study, we refer to third parties to describe people not directly observing violations, but learning about violations afterwards.

In a survey of 1,702 university employees (51% women), findings showed that female bystanders and third parties reported a lower perception of safety (Miner & Cortina, 2016), which suggests that knowing about uncivil treatment of others affects working and private life.

Recent studies of bystanders/third parties and psychological violence in the workplace are scarce, particularly with regard to academic medicine. To close this gap in the literature, the purpose of this exploratory qualitative study was to obtain an understanding of psychological violence and its interplay with gender in academic medicine. The explicit aim was to examine third parties' perceptions of psychological violence. We conducted in-depth interviews with women who were part of a working group on equal treatment at one medical university in Austria, Europe. This group monitored discrimination and harassment in the workplace.

Methods

We approached members of a working group on equal treatment at one Austrian medical university. Based on the main responsibilities of the group, we considered members of this working group to be third parties and experts on unequal treatment, discrimination and psychological violence in the workplace. The working group consisted of members from all hierarchical levels of the organization (administrative staff, student body, mid-level faculty and professors) and included medical doctors, natural scientists, administrative staff, and students.

Under hospital legislation ("Hospitals and Health Resorts Act") and the Austrian university act ("Federal Act on the Organisation of Universities and their Studies"), this study did not require approval by the ethics committee of the medical university, because the study neither involved patients nor required medical treatment or other medical procedures. In addition, the ethics committee at this medical university confirmed that the study did not require approval by the ethics committee. To recruit participants, we sent an email invitation to all members of the working group. Before conducting the interviews, participants gave written informed consent for findings to be recorded and published. Participation was voluntary and participants were able to withdraw from the study at any time. Recordings were transcribed verbatim and anonymized. The final transcripts did not contain any identifiers regarding persons, places, or time. Colloquial wording was transcribed in standard language and nonverbal cues such as laughing were included in transcripts.

Interviews

An independent interviewer conducted face-to-face interviews with the participants, using a semi-structured interview guideline (see Table 1). This procedure allowed ad hoc questions and comparability between interviews (Witzel, 2000). We based interview topics on literature research and the working group's focus on work-related discrimination. Topics covered intent and focus of the working group as perceived by the participants, and questions on psychological violence. We specifically used this term to underline the importance of the

Table 1. Interview Questions Pertaining to Psychological Violence in Academic Medicine

Main questions	Potential follow-up questions
What focus do you see for yourself in the working group?	Years of work experience Motives for engagement, interests
Where are the boundaries of psychological violence?	Definitions of psychological violence
What experiences do you have with those affected by psychological violence?	Description of experiences Coping-strategies of those affected Gender aspects (impact, outcome of experiencing psychological violence)
What experience do you have with female perpetrators of psychological violence?	Gender aspects in perpetrating psychological violence
What do you perceive as triggering psychological violence?	Gender aspects in triggers
What is your experience regarding the so-called cycle of violence?	Opinion on cycle of violence
What solutions do you see in counteracting psychological violence?	Protecting oneself/others Coping with psychological violence
What is the role of emancipation in the psychological violence context?	Emancipation and empowerment of women

subject and the gravity of this behavior. We asked participants about their definition of psychological violence, and about gender aspects of those affected by and those perpetrating such violence. We included questions on the effect of emancipation and gender equality to cover power structures, and women's rights in the interviews. The interview ended with participants given the opportunity to make additional comments. Interviews were conducted in German and translated into English after analysis. A native English speaker who is fluent in German and the regional colloquial language supervised translation.

Data Analysis

All interviews were audio-recorded, except for two participants who refused recording but gave their consent for notes to be taken. We chose grounded theory based on Strauss and Corbin (1990) for analysis, as we were interested in the process of psychological violence and its effects as perceived by these participants. This approach underscored that participants have a voice (Strauss & Corbin, 1994) and helped to create a story about psychological violence in medical culture.

First, we used open coding to select important aspects in the data. In this process, questions helped with fragmentation of data (Ruppel & Mey, 2015; Strauss & Corbin, 1990). In our case, questions referred to, for example, who the main actors in the participants' narrations were, in what situations psychological violence occurred, and how participants described the role of gender. These questions facilitated coding of most important aspects. We wrote down thoughts and questions as memos and included them in the analysis along the way. We used Maxqda© software (2018) for open coding of data and paper and pencil mode for subsequent steps. We re-read all codes several times, arranged them according to their similarity, and attached concepts to these groups of codes. The concepts were then grouped into higher-order concepts, also called categories (Strauss & Corbin, 1990).

Third, axial coding was performed to identify connections between categories. We used the paradigm model to detect the phenomenon, causal conditions, context, actions and interactions, intervening conditions, and consequences and highlight relations between categories (Ruppel & Mey, 2015; Strauss & Corbin, 1990).

Fourth, the previous arrangement of categories enabled the phenomenon in the narrations to be uncovered and the basis for a stringent story to be developed. This procedure also included going back and forth in the data to pursue potential stories underlying the data—which was part of selective coding. Ruppel and Mey (2015) wrote that "[s]elective coding demands further refinement of categories, and their integration into a network through the establishment of a core category" (p. 178). The core category is the center of the story. It can be described as the story line.

During analysis, categories achieved sufficient conceptual depth and range (Nelson, 2017) and a conclusive picture

emerged of the subject of psychological violence in the context of medicine. We achieved saturation of data, because no new insights emerged when coding the last interviews and because there was variation within the categories (Strübing et al., 2018). Reflection during analysis meant discussing prior knowledge of the subject from previous studies, other research, or experiences with the topic. These reflections helped explore alternative meanings of findings and construct voices in the story. One of the study researchers initially analyzed the data followed by a second. Inconsistencies in the coding process as well as when engaging in axial and selective coding were discussed between these authors. If necessary, initial steps in the coding process were repeated together.

Findings

Of 20 eligible persons, 12 women participated in the interviews. Their median years of working experience in the working group was 3.5 years (range: 0.15–25 years).

Three categories evolved around the core category "power struggles in the fortress of academic medicine." These three categories referred to gendered structures in medicine, the complexity of psychological violence, and supporting women in medicine. The core category provided the frame in which the categories operated. The core category symbolized the hierarchical and rigid organization of medical culture. Slow progress in changing the medical culture was characteristic of this "fortress." This was supported by a participant who stated, "before they [i.e., men in power] accepted women, they had honorary men, they maintained the system by viewing the inevitable woman as a man" (Interview 11). Gendered power relations in academic medicine have thus grown historically, which was emphasized by a participant who reported that "the structure was built by men" (Interview 10). Professional socialization appeared to be intertwined with the gendered structures and relations in the medical culture. This meant that most female staff had to adjust to the rigid structure to progress in their career as illustrated by this participant: "women who got to the top in this system, they had to adjust extremely to the predominant conditions." (Interview 10)

Connected to the core category was the category that covered gendered structures in medicine that shaped the working environment and focused explicitly on the gendered constructions in academic medicine. Women and men were mostly described as representing different categories of members of academic medicine. Women were seen as frequently facing disadvantages because of characteristics attributed to them that were diametrical to the mostly masculinized structures.

The second category connected to the core category represented the complexity of psychological violence. Psychological violence could potentially affect anyone, be a planned action of longer duration, restrict others in their actions or freedom, and was often subtle. Some attributes made psychological violence difficult to define and easy to misunderstand. Outcomes of psychological violence (i.e., harm) were observed as termination of contracts, and also health impacts regarding physical or mental health.

Finally, the third category supporting women in medicine was seen in the context of gendered structures that created different conditions for women and men and in which psychological violence was vague but a potential threat. Supporting women referred to offering solutions to counteract psychological violence, encouraging incidents to be reported, strengthening self-worth, or sanctioning violations.

Category 1: Gendered Structures in Medicine

Gendered structures became visible when participants' descriptions focused on women overcoming obstacles that appeared to affect mostly or only women or were disadvantageous for women. The structures resulted in gender-specific accessibility of careers in academic medicine. These structures were shaped by an interconnectedness of power and gender.

Interconnectedness of power and gender in medicine

Most participants discussed the fact that power was an essential aspect in medicine and created a chasm between persons in higher and lower ranks. Psychological violence and power are—sometimes—interconnected as described by a participant in the following quote:

> [. . .] if you can do it, you will do it. It is simply a matter of power, it is just like sexual violence in my opinion, it is claiming power, like "I can take the liberty to do it, I can do it." (Interview 11)

Power relations regarding weakness and gender were discussed. Some women were considered to be "weaker" in their accumulation of power than were most men. As psychological violence was exerted against those with less power, women were more often affected by violence than were their male counterparts, as explained by this participant:

> It is not a woman-question, but a power-question, [about] who is resisting. Of course, it affects the weak ones, [. . .] and as a woman in order to be credible you have to [. . .] give those in power positions a bloody nose, so they remember [. . .]. But I believe [psychological violence] affects the weak ones and unfortunately here women are the weak ones and they are seen as the weak ones; but I believe psychological violence is mostly violence against the weak ones and to a lesser extent against women. (Interview 11)

Some men in higher ranks were seen as those exerting psychological violence, but interviewees also discussed the observation that this perception was conflated with fewer women being at the top of the hierarchy and fewer women having a chance to act this way. This also referred to medicine

as a system formerly established by men and still favoring men over women in their careers. Women had to find their way into this masculinized structure. A participant described this:

> In the end, the structure was built by men and it was built a certain way. So it works, [designed with a view to] what [men] are like and we [women] have to find our way into that, so to speak. (Interview 10)

Some participants described women and men in relation to differences due to gender. Some women were observed as handling difficulties in other ways than did most men. Women and men were often seen as representing different categories of members in academic medicine. Men were perceived differently as described by this participant:

> They've learnt how to deal with it [psychological violence], it is a bit like that doesn't affect me anymore [. . .] they are better at distancing themselves [and say] ok, it concerns me so far and no further and everything else doesn't concern me; not like us women, who take it more to heart. (Interview 7)

Tolerating situations in which psychological violence occurred was associated with femininity. This was expressed by a participant as "condoning and bearing is very feminine" (Interview 1).

Category 2: The Complexity of Psychological Violence

Psychological violence was noticeable in action and interaction. Two sub-categories illustrated the various ways in which participants understood violence by depicting its attributes, as well as negotiating behavioral patterns and actions connected to misunderstanding psychological violence.

The pedals of psychological violence

Interviewees saw psychological violence mostly in the context of bullying, as described by one participant, "Psychological violence starts with bullying and it happens on a daily basis, it happens daily in medical work" (Interview 13). Psychological violence was described as a harsh speaking tone, discrimination, and inequality. Particularly, subtle forms of psychological violence were observed as being exerted without intent to harm, as one participant stated, "psychological violence may occur in the form of ignoring or ostracism, but no action is taken pro-actively" (Interview 3).

When discussing less subtle forms of psychological violence, participants saw it as longer-lasting, planned actions, restricting or isolating people, and harmful to people. Harm included sick leave, physical illness, and psychological harm ranging from anxiety, loss of self-confidence to burnout. Harm might result in interrupting one's career progress in terms of terminating a contract or rotating to a different workplace within the university. Psychological violence as a hopeless situation was also described in the following quote:

> [. . .] that you cannot escape the situation and [. . .] it is mostly a colleague who is the problem and who makes work impossible, virtually, plenty of intrigues, talking behind your back and essentially it results in someone saying 'that's enough' and 'I'm obviously not welcome' and essentially it is a very hopelessly muddled situation. (Interview 8)

Participants reported that acts of psychological violence were unwanted, and affected the person emotionally, as also described by this participant "[. . .] often they wish to change their working place, to escape the situation, and you notice that they are very burdened by it" (Interview 3).

Misunderstanding psychological violence

Participants considered the challenge to outline the range of psychological violence and its boundaries. It also meant doubting intent to harm. Participants discussed, for example, constant pressure to improve performance. Demands to improve performance, for example, publishing scientific research, were not named as psychological violence per se. Interviewees pointed out that pressure to increase performance might sometimes be disproportionate. Some interviewees also wondered if such pressure was misinterpreted as psychological violence, as one participant indicated, "[psychological violence] has only very vague boundaries, because psychological violence or some situations that are psychological violence for one person, are normal stress situations for others. The boundaries are very individual and differ from person to person" (Interview 12).

Pressure to increase performance was felt at all hierarchical levels. Therefore, persons in higher ranks were forced to transfer such pressure to those in lower ranks. The delegation of pressure to lower ranks was considered a natural consequence, as described by this participant:

> Conditions have worsened in recent years because of the pressure to perform, increase efficiency, increase performance, improve your proven record of success, and there is a lot of pressure at all [hierarchical] levels that is merely passed down to [those in] lower ranks [by people in higher ranks]. (Interview 10)

Participants discussed the intent of potentially violent acts. This included acts due to time constraints that were misunderstood as psychological violence as this participant stated, "Time issues prevent you [as a boss] from being responsive to everyone. The boss is not necessarily a conscious perpetrator [of psychological violence]" (Interview 5).

Category 3: Supporting Women in Medicine

Supporting women ranged from the tasks of providing support and monitoring gender equality to finding solutions in cases of discrimination or psychological violence.

Solutions to counteract psychological violence

Solutions to react to psychological violence were based on a collective level, which included the whole university, and on individual levels. The whole organization was prompted to assume responsibility, as one participant described that "everyone is duty-bound [to do something] and I think really every single person in the working environment and I believe this can only be achieved via public [awareness]" (Interview 10). Collective levels referred to raising awareness for psychological violence, its facets, subtlety, and misinterpretations, whereas individual levels referred to strengthening the individual. This included making a client aware of her or his rights, as a participant emphasized:

> To make yourself aware that you [as a woman] have the same right as a man and that you can also claim [the same right], that is a matter of fact. And that probably strengthens your awareness, your self-confidence. (Interview 2)

Participants also discussed the standpoint that women's emancipation secured a certain status for women also in terms of employment and career possibilities, including liberation from outdated social limitations. Simultaneously, participants referred to empowerment of women in terms of women setting boundaries, self-determination and being aware of equal rights. Thus, emancipation and empowerment were seen as beneficial, but did not make women invincible in this context. Sometimes emancipation and empowerment of women were observed as causing more insecurity in men. Consequently, some men did not know how to interact with women, as reported by this participant:

> I think for some men it is extremely difficult to tolerate the fact that you as a woman might have equal status or position and that he might overrate his own capabilities or be too vain to accept this and in this context emancipation plays an important role [. . .] previously, when you didn't have to do the same work, many men from that generation think things still have to be that way [. . .] (Interview 8)

Discussion

In this study, we focused on the perception of psychological violence in the medical workplace by female third parties, who monitor equal treatment, discrimination, and harassment. Internationally, studies have shown that psychological violence in the workplace and in academic medicine affects women more often than it does men, particularly regarding sexual harassment (Vargas et al., 2020).

Our core category illustrated that academic medicine was characterized by a rigid culture, symbolized by a fortress. For instance, our participants observed a stability of gendered structures over time as the existence of female "pioneers" in different ranks did not guarantee progress regarding gender equality. Stability is also one characteristic of organizational culture (Scott et al., 2003), in addition to characteristics of shared practices and beliefs (Braithwaite et al., 2017). In our study, gendered structures appeared to be one part of the organizational culture because of their stability over time and because they were upheld by general beliefs about gender differences. However, our participants also reported that women liberated themselves from outdated social limitations and became empowered in the sense of being aware of equal rights. Emancipation and empowerment were therefore diametrically opposed to the (mostly outdated) gendered system of medicine.

In our study, women were seen to be more often in positions that afforded less power and less often in higher ranks. This also meant that gender and power/weakness were conflated in our participants' narrations: "weak" persons defined as those with less power were more often exposed to psychological violence. Similar observations were made by McCord et al. (2018), who concluded that due to follower positions and gender, women might experience double jeopardy. Also Vargas et al. (2020) found sexual and gender harassment to be more frequent in lower positions and to affect women more often. However, seniority was also found to have a buffering effect (Vargas et al., 2020). This supports our participants' perception. Thus, power in terms of seniority and position might be considered protective characteristics.

Characteristics of psychological violence as proposed by Hamby (2017)—behavior that is (a) intentional, (b) harmful, (c) nonessential, and (d) unwanted—could not always be detected in our participants' narrations, especially in subtle forms. Participants doubted the intent to harm in harsh communication or other subtle behavior. However, Berry et al. (2016) reported that it is vital to give those affected the power to perceive intentionality. Otherwise, denial of intent can be used as an instrument of power and harm. Regarding the second characteristic, harm, participants described harm as resulting from these experiences. Also the third characteristic, violence being nonessential, could often be considered fulfilled. However, we would like to note that participants did not explicitly refer to that characteristic. Finally, we can only assume that acts were unwanted and participants did not explicitly report about this aspect. Consequently, we conclude that not all reported acts fulfilled the criteria for psychologically violent behavior as proposed by Hamby (2017).

This study was not without limitations. We had no information on the people who declined to participate. We can only speculate why some chose not to take part in the study. Only a select group was recruited for the interviews and participants were exclusively women. This was due to the fact that at that time the working group included few men. One man agreed to participate in the study; consequently, men were

inadequately represented in our study, which also threatened anonymity for this participant. Therefore, we decided to exclude this interview from analysis. In addition, in the literature as well as in our study there is a greater focus on how psychological violence affects women, and intersections such as age, class, and ableism are hardly considered in the context of psychological violence in academic medicine. Findings focused on one medical university only; however, we believe that similar observations can be made at other institutions, as shown in commentaries (Grant-Kels, 2017; Jagsi, 2018).

As medical universities employ different groups of scientific, clinical, and administrative staff and cover a broad range of disciplines, it would also be interesting to differentiate between various disciplines and professions in future studies. If we are to acquire an inclusive picture of academic medicine and the medical culture, all these voices have to be included.

Conclusion

Not all acts observed by our participants could be unequivocally classified as psychological violence according to Hamby's (2017) definition of violence. The characteristic that was doubted the most was intent to harm. Further studies should assess whether such doubt can be attributed to coping strategies and beliefs in the basic good of people, or whether intent is indeed lacking. However, intent should be defined not only by those perpetrating violence as it potentially increases harm if intent is repeatedly denied (Berry et al., 2016).

Debating intentions of psychological violence, health workers having to deny vulnerability, and lower positions (i.e., the "weak") posing a potential threat to experience harm can be interpreted as signs of a culture with a detrimental effect on health workers. It also affirms what interaction and what display of behavior is considered appropriate.

Implications for occupational health practice

From our study and the scientific literature, we deduce that all hierarchical levels and genders bear the responsibility to initiate change. Such actions for change can be realized on the individual level. On this level, initiating change includes implementing training for all to learn the characteristics of psychological violence (i.e., intent, harm, nonessential, unwanted); providing public and repeated information (e.g., folder, posters, announcements at the beginning of public lectures) on reporting possibilities; focal contact points and sanctions with the aim of breaking taboos; and offering protection to those targeted by psychological violence and to those reporting violence. This protection must be regardless of the target's position and power and must exceed the protection enjoyed by those in power.

Initiating change on the collective level refers to providing all hierarchical levels with a voice to (anonymously) suggest change, and to regularly report pitfalls and benefits. There should be a transparent display of suggestions put into practice to show that everyone has a voice. In addition, trainings about organizational culture should be offered to flatten hierarchies and to promote a positive psychological leadership style (leadership training). Change at the system level includes stopping the accumulation of power in higher ranks. In this context, persons in higher/more senior positions should not have power over those in lower/junior positions. For instance, to avoid such concentration of power, additional independent assessments for juniors/lower positions (e.g., when discussing annual target agreement) should be implemented. In addition, diversity in career patterns and working styles should be promoted. This should prevent othering of women. Such diversity should be included in the university statutes and made transparent.

Despite the outcry to change medical culture (Bates et al., 2018), too few ideas have been put into action. Currently, emancipation and empowerment on a societal level are diametrically opposed to the mostly outdated gendered system of medicine. Interventions are prone to fail if an organizational culture affirmed by outdated beliefs about power and gender prevents these interventions from becoming effective. Thus, every individual has the responsibility to implement change (such as proposed above) in her or his working environment.

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Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Compliance With Ethical Standards

To respect participants' well-being, protect their rights, including their right of self-determination, confidentiality, and voluntary participation, we sought informed consent from all persons involved in the study. We first obtained approval of the head of this working group. We then informed members about purpose and content of the study via email. Participation was voluntary. All participants signed a letter of consent to permit the interview to be recorded and the findings to be anonymously published. Recordings were transcribed verbatim and transcripts were anonymized in due course.

Ethical Approval

According to legislation (Hospitals and Health Resorts Act and Federal Act on the Organisation of Universities and their Studies), this study did not require approval from the ethics committee of this medical university. Ethics committees approval is required if the study involved patients or required medical treatment or other medical procedures ("Hospitals and

Health Resorts Act") The study at hand does not meet these requirements. No approval by the ethics committee was obtained. The ethics committee of this medical university provided confirmation that this study did not require approval of the ethics committee.

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References

Aysola, J., Barg, F. K., Martinez, A. B., Kearney, M., Agesa, K., Carmona, C., & Higginbotham, E. (2018). Perceptions of factors associated with inclusive work and learning environments in health care organizations: A qualitative narrative analysis. *JAMA Network Open*, *1*(4), Article e181003. https://doi.org/10.1001/jamanetworkopen.2018.1003

Bates, C. K., Jagsi, R., Gordon, L. K., Travis, E., Chatterjee, A., Gillis, M., . . . Flotte, T. R. (2018). It is time for zero tolerance for sexual harassment in academic medicine. *Academic Medicine*, *93*(2), 163–165. https://doi.org/10.1097/acm.0000000000002050

Berry, P. A., Gillespie, G. L., Fisher, B. S., & Gormley, D. K. (2016). Recognizing, confronting, and eliminating workplace bullying. *Workplace Health & Safety*, *64*(7), 337–341. https://doi.org/10.1177/2165079916634711

Bradley, V., Liddle, S., Shaw, R., Savage, E., Rabbitts, R., Trim, C., . . . Whitelaw, B. C. (2015). Sticks and stones: Investigating rude, dismissive and aggressive communication between doctors. *Clinical Medicine*, *15*(6), 541–545.

Braithwaite, J., Herkes, J., Ludlow, K., Testa, L., & Lamprell, G. (2017). Association between organisational and workplace cultures, and patient outcomes: Systematic review. *BMJ Open*, *7*(11), Article e017708. https://doi.org/10.1136/bmjopen-2017-017708

Crowe, S., Clarke, N., & Brugha, R. (2017). "You do not cross them": Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine*, *186*, 70–77. https://doi.org/10.1016/j.socscimed.2017.05.048

Escribano, R. B., Beneit, J., & Luis Garcia, J. (2019). Violence in the workplace: Some critical issues looking at the health sector. *Heliyon*, *5*(3), Article e01283. https://doi.org/10.1016/j.heliyon.2019.e01283

European Institute for Gender Equality. (2020). *Glossary & thesaurus: Psychological violence*. https://eige.europa.eu/thesaurus/terms/1334

Federal Act on the Organisation of Universities and their Studies, [Universitätsgesetz 2002—UG], Federal Law Gazette 1, Pub. L. No. 120/2002 as amended by 21/2015 § 30 (2002/2015).

Grant-Kels, J. M. (2017). Sexism in medicine, circa 2016-2017. *International Journal of Women's Dermatology*, *3*(1), 68–69. https://doi.org/10.1016/j.ijwd.2017.01.007

Hamby, S. (2017). On defining violence, and why it matters. *Psychology of Violence*, *7*(2), 167–180. https://doi.org/10.1037/vio0000117

Hershcovis, M. S. (2011). "Incivility, social undermining, bullying. . . oh my!": A call to reconcile constructs within workplace aggression research. *Journal of Organizational Behavior*, *32*(3), 499–519. https://doi.org/10.1002/job.689

Hirayama, M., & Fernando, S. (2018). Organisational barriers to and facilitators for female surgeons' career progression: A systematic review. *Journal of the Royal Society of Medicine*, *111*(9), 324–334. https://doi.org/10.1177/0141076818790661

Hospitals and Health Resorts Act, [Bundesgesetz über Krankenanstalten und Kuranstalten—KAKuG], Federal Law Gazette 1, Pub. L. No. 1/1957 as amended by No. 3/2016 § 8c (1957/2016).

Jagsi, R. (2018). Sexual harassment in medicine - #MeToo. *New England Journal of Medicine*, *378*(3), 209–211. https://doi.org/10.1056/NEJMp1715962

Katz, J. (2018). Bystander training as leadership training: Notes on the origins, philosophy, and pedagogy of the mentors in violence prevention model. *Violence Against Women*, *24*(15), 1755–1776. https://doi.org/10.1177/1077801217753322

Maxqda. (2018). *Maxqda software for qualitative data analysis* (Version 11). VERBI Software—Consult—Sozialforschung GmbH.

McCord, M. A., Joseph, D. L., Dhanani, L. Y., & Beus, J. M. (2018). A meta-analysis of sex and race differences in perceived workplace mistreatment. *Journal of Applied Psychology*, *103*(2), 137–163. https://doi.org/10.1037/apl0000250

Miner, K. N., & Cortina, L. M. (2016). Observed workplace incivility toward women, perceptions of interpersonal injustice, and observer occupational well-being: Differential effects for gender of the observer. *Frontiers in Psychology*, *7*, 482–482. https://doi.org/10.3389/fpsyg.2016.00482

Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, *17*(5), 554–570. https://doi.org/10.1177/1468794116679873

Ruppel, P. S., & Mey, G. (2015). Grounded theory methodology—Narrativity revisited. *Integrative Psychological and Behavioral Science*, *49*(2), 174–186. https://doi.org/10.1007/s12124-015-9301-y

Scott, T., Mannion, R., Davies, H. T., & Marshall, M. N. (2003). Implementing culture change in health care: Theory and practice. *International Journal for Quality in Health Care*, *15*(2), 111–118. https://doi.org/10.1093/intqhc/mzg021

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. SAGE.

Strauss, A., & Corbin, J. M. (1994). Grounded theory methodology. An overview. In N. K. Denizin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). SAGE.

Strübing, J., Hirschauer, S., Ayaß, R., Krähnke, U., & Scheffer, T. (2018). Gütekriterien qualitativer Sozialforschung. Ein Diskussionsanstoß [Criteria for qualitative research. A stimulus for discussion]. *Zeitschrift für Soziologie*, *47*(2), 83–100. https://doi.org/10.1515/zfsoz-2018-1006

Sue, D. W. (2010). Microaggressions, marginality, and oppression: An introduction. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 3–22). John Wiley.

Vargas, E. A., Brassel, S. T., Cortina, L. M., Settles, I. H., Johnson, T. R. B., & Jagsi, R. (2020). #MedToo: A large-scale examination of the incidence and impact of sexual harassment of physicians and other faculty at an academic medical center. *Journal of Women's Health*, *29*(1), 13–20. https://doi.org/10.1089/jwh.2019.7766

Witzel, A. (2000). The problem-centered interview. *Forum Qualitative Social Research*, *1*(1), Art. 22. https://doi.org/10.17169/fqs-1.1.1132

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