Working Papers WP 2020-02
Centre for German and European Studies (CGES)

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Male and Female Medical Workers Occupied in Non-Traditional Professions in United Kingdom and Republic of Ireland: Biographical Analysis of Their Careers

WP 2020-02

2020
№ 2

St. Petersburg / Bielefeld

Centre for German and European Studies (CGES)

St. Petersburg University

Bielefeld University

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This paper is based on an MA thesis supervised by Dr. Vladimir Illin and defended in June 2020 at the MA 'Studies in European Societies' supported by the CGES. The thesis was recommended for publication in the CGES Working Papers series by the Examination Committee as one of the best theses defended by the students of the MA 'SES' in 2020. The author expresses gratitude to the CGES for financial and organizational support in having international experience during the course of the studies.

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ISSN 1860-5680

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Introduction

One of the greatest changes that the labour market has experienced in the last century is a major increase in women participation in the paid labour force. However, gender segregation of labour market persists, with some spheres remaining male- and female-dominated. Such segregation creates inequalities for workers occupied in non-traditional professions, starting from the gender pay gap and ending with gender identity conflict and crisis. I will place these people's experiences at the centre of my study in order to understand what consequences of gender segregation of labour market people face and thus what influence gender has on their professional lives.

In my study, I will focus on the specific context of the medical sphere of United Kingdom and Republic of Ireland as these two countries present an interesting case for the research. On the one hand, their cultural proximity to North American context makes it possible to rely on the extensive body of empirical and theoretical research that already exists. And on the other hand, differences in the healthcare systems in comparison with the US context open a gap in which specific aspects that have not been researched yet emerge.

For the purpose of my study, I have chosen two medical professions that are traditionally perceived as male and female: surgery (Hill et al., 2015) and nursing (Snyder & Green, 2008) respectively. Statistical data proves that these two occupations remain female- and male-dominated – 89% of nursing personnel in England are women (*International Women's Day – Women in the NHS Workforce*, n.d.) while in surgery women constitute only 27% of all workers (*Narrowing of NHS Gender Divide but Men Still the Majority in Senior Roles*, n.d.). The situation in the Republic of Ireland is similar: men constitute 87% of surgeons (*Consultant Workforce 2018*, 2018) and only 4% of the nursing workforce (Keogh & O'Lynn, 2007).

Despite the fact that the experiences of people working in non-traditional professions have been widely investigated in existing literature, some gaps remain. Existing research on male nurses has a long-running history and tradition, however, there seems to be a fragmentation of topics across different studies and disciplines, thus I will try to compound previous results and my findings in a broader picture. Studies that concern female surgeons are also not unique, however, the vast majority of them investigate the case of the United States, deriving from the data collected there, and are guided by the local healthcare system environments. Besides, the majority of studies employs quantitative methods of research addressing quite particular inquiries in an attempt to provide an objective view on different issues, thus the existing body of literature somewhat lacks the narratives and voices of women surgeons themselves.

To address this issue, I will adopt a qualitative methodology that (a) can help to identify aspects and details that might have been overlooked in previous quantitative research; (b) follows a feminist tradition that makes it possible to enrich the study with people's perspectives and researcher's interpretations which is impossible to achieve through somewhat rigid assumptions of quantitative research that might have inherent gender bias (Liang et al., 2019).

Through collecting semi-structured in-depth Skype interviews, I will investigate the *subject of this study* – education- and work-related experiences of male nurses and female surgeons in the United Kingdom and the Republic of Ireland. My informants – male nurses and female surgeons in the United Kingdom and the Republic of Ireland – will be the *object of the study*.

The *key research question* that I aim to answer in my research is: "What is the role of gender in self-perception of education- and work-related experiences of male and female medical workers occupied in non-traditional professions?"

In order to answer this question, I will address the following *research objectives*:

- To analyse the role gender plays in self-perception that male and female medical workers occupied in non-traditional professions have regarding their professional education and work.
- To analyse role gender plays in self-perception that male and female medical workers occupied in non-traditional professions have regarding their relationship with their patients, colleagues, superiors, subordinates and "outsiders".
- To analyse ways in which male and female medical workers occupied in non-traditional professions conceptualise themselves within existing stereotypes about their professions.

My research will be organised as follows. First, I will outline a theoretical framework that I will use in my study. This will include brief insight into the process of development of gender studies and the concept of gender itself. Then, I will outline the integrative paradigm that conceptualises gender as a social structure which I find most suitable for my research. After that, I will move to the issue of gender segregation of the labour market and present literature that attempts to theorise reasons for this phenomenon. Afterwards, I will present concepts that are critical to studying people occupied in non-traditional professions: token theory and "glass escalator". I will finish the theoretical part of my study with a literature review of the existing research about male nurses and female surgeons.

The second part of my study will describe the methodology of the research and present analysis of the collected data. I will begin with the analysis of eight interviews with female surgeons through the lens of my three objectives: education and work, relationship with patients, colleagues, superiors, subordinates, and "outsiders", and stereotypes about the profession. Then, seven interviews with male nurses will be analysed through the same focal points. To summarise, I will present the conclusions and results of my study.

1. Theoretical framework of the study

1.1. Gender and labour market

I would like to start my research by outlining the theoretical framework of the study. It will be conducted in the tradition of feminist and gender studies and thus I shall begin with briefly presenting the development of this field of social sciences and clarifying what will be understood under the term “gender” throughout the whole paper. Then I will present a theoretical paradigm in line with which I will build my study and conceptualisation.

1.1.1. Conceptualising gender

Studying gender has a long and rich tradition in different spheres of scientific knowledge. As Risman (2018, p.7) wrote: “In many ways the research on gender is a case study that illustrates the scientific method.” In this part I will present studies that aimed to understand what sex and gender are, what are the (real) differences between men and women, and how sex and gender function in the society. Importantly, the great majority of this research was concerned with questions about gender inequality and social change that society needs to overcome this inequality. I will begin with theories that tried to explain societal sex differences from a biological standpoint, then I will outline psychological and sociological theories that approach gender as a personality trait and use the concept of sex roles, and then I will present sociological theories that analyse gender as a product of interaction and gender as a product of social structures’ functioning.

Biological determinism

There are three major biological theories that were prominent in the last century in their attempts to explain the observed social differences between men and women. The first one, sociobiology, argues that humans have an evolutionary urge to pass on their genes to further generations. Speculating on Darwin’s theory, it claims that those individuals who follow the most successful reproduction strategies see this goal fulfilled. These reproduction strategies presuppose certain psychological characteristics that together with the desire to continue the genetic line become an innate genetic code that affects the whole body – including brain and hormones – and through it, human behaviour (e.g. Wilson, 1975, Tavris et al., 1984)

The tricky part is that successful reproduction strategies, sociobiologists claim, are inherently different for men and women and thus they are different by virtue of nature itself. It is claimed that men are aggressive, violent and dominating because these are the ways to reproduce more and better offspring. Women are passive and nurturing because these are the strategies that maximise survival of their genes (Barash, 1979). Thus rape, incest, abandonment of

children along with racism, xenophobia and sexual promiscuity are claimed to be inherent to human society, proclaiming biological inevitability of their occurrence (Barash, 1979).

According to other theory, male and female brains are claimed to have significant differences that lead to different mathematical, linguistic, spatial and cognitive abilities (e.g. Geschwind, 1979, DeLacoste-Utamsing & Holloway, 1982). While not explicitly stating female inferiority, this theory assigns certain spheres of human activities as biologically more appropriate to man and others – to women.

Another theory that investigates particular biological difference and connects it to human social behaviour is prenatal hormone theory. To put it briefly, it extrapolates biological evidence that sex differentiation occurs during the prenatal period due to embryos' testosterone exposure from mammalian species to humans. Such exposure, the theory claims, does not just shape the bodies but also affects brains and thus hormones and behaviour (for review see Bem, 1993). In other words, it, first, supports the above-mentioned theory of brain difference between men and women and, second, claims this pattern to be determined by biology firmly, permanently and irreversibly.

Despite the wide popularity of these theories, they were not left uncriticised. The first point of critique concerns the fact that a lot of the above-mentioned conclusions were made based on the data collected about animals. It is indeed an open question to what extent these conclusions can be extrapolated to humans whose brains as well as social structures are way more complex than those of animals. The second problem that is not sufficiently addressed in these theories is the interaction between humans themselves and their environments. The ability of humans to transform their surroundings as well as to create societies with complex structures, norms and customs are not accounted for. In these theories human beings seem to be unaffected neither by upbringing nor technological progress, remaining, in a way, primitive creatures from the dawn of history, despite the evidence from anthropology and, in fact, biology, that context, first, varies so significantly across cultures that there are almost no universalities about male and female, and, second, allows or prevents certain biological predispositions from developing (Bem, 1993; Epstein, 1988).

Sex-role theory and where it leads us

Before the feminist movement of the second wave, little sociological research was conducted on the topic of sex and gender. "Women's" issues were addressed mainly in the context of family or motherhood and little attention was paid to what position and why women occupy in the society. A functionalist theory proposed by Parsons (1942, also Bales & Parsons, 1955/2014) – sex-role theory – stated that men and women have different functions in the society – instrumental and expressive respectively. This theory ascribed sex-roles to men and women: for a man it meant being a breadwinner, for a woman – a mother and wife. Efficacy, leadership, logic – were qualities of a man. Being

caring, nurturing, empathic – of a woman. These roles were seen as complementary, and the theory denied the existence of power relations between the two of them.

As biologists tried to explain how nature has made men and women socially different, psychologists tried to prove the same point through uncovering psychological differences between them. Before 1970-s they used scales to measure masculinity and femininity within one's personality where these two characteristics were in opposition to each other, thus men could only have low or high masculinity score and women low or high femininity score. Bem (1974, 1993) proposed a revolutionary concept according to which personality of both biological men and women actually had two dimensions – masculine and feminine. Thus, she deconstructed an oppositional dichotomy of masculine (agentic, logical) and feminine (nurturant, caring) characteristics, suggesting that one person scores on both scales no matter what their biological sex is.

Following psychological research, sociologists wanted to discover a source from which people acquire these feminine and masculine characteristics. These studies investigated how traditional sex roles are learned through socialisation in childhood: how early on children's surroundings (toys, clothes, etc.) are gendered, how they are encouraged to play games that exercise appropriate to their sex social skills, how they are praised for conformity to the stereotype about their sex and how they are socially punished if they fail to comply (e.g. Weitzman et al., 1972, Kane, 2012). Research in this area highlighted that girls participate in such forms of activities and are specifically taught skills that are useful for family life and housekeeping while boys learn more organisational and cooperative skills which teach them more about professional life outside of home (e.g. Lever, 1976; Epstein, 1988). Thus, what later on appears to be natural preferences and results of free choice, are, in fact, results of strictly gendered socialisation.

However progressive this finding might look, further research pointed out to two major weaknesses of the sex-role theory. Firstly, it is assumed that as soon as a person is socialised into being men or women these learned traits and behaviours are continuous and stable throughout all their lives, whilst reality demonstrates that it is not so and people do adopt traits and skills of opposite sex later on if they want or need to (Risman, 1987). People do change their values and beliefs in the course of a lifetime under external circumstances, demonstrating that socialisation is not that deterministic as it was believed to be. Neither do all people socialised to fit the sex roles accomplish the task or are happy within their role (Risman, 1998).

That leads us to the second problem of the sex-role concept. It completely depoliticises relationship between men and women, ignoring political, economic, and cultural development of the question. Roles are claimed to exist as complementary, as something personal, as something that has nothing to do with any other social structure. Sex role also presupposes homogeneity among all men and all women, ignoring class, race, and other demographic characteristics. And finally, sex role theory happens to not fit into the sociological concept of a role because according to it, role presupposes relations that arise because of this role's functions. However, there is no function that one has solely because of their sex. Gender entails expectations about which other

social roles person will choose or how he or she will perform them but it does not provide any function by itself. Gender appeared to be a deeper and more complicated phenomenon than sex-role theory had suggested (Lopata & Thorne, 1978).

Doing gender

This critique of sex-role theory led to the development of other perspectives about what gender is and how it functions in society. One of such perspectives is the concept of "doing gender" proposed by West and Zimmerman in 1987. In their classic article, they have achieved two important goals. First, they suggested clear differentiation between three concepts that up until then were used somewhat confusingly and interchangeably: sex, sex category and gender. Person's sex could be defined by application "of socially agreed upon biological criteria" (West & Zimmerman, 1987, p.127), sex category – by an "identificatory display" (West & Zimmerman, 1987, p. 127) via which one signals in which category they should be placed, and gender – by managing social situations in accordance with norms that are appropriate for the sex category, membership in which one claims (West & Zimmerman, 1987). Besides, they argued that one's sex category (and thus gender as well) does not necessarily correspond to one's sex, drawing on the case of a transsexual women Agnes described by Garfinkel (1967). Further on in my research, I will adopt this terminology regarding sex, sex category, and gender.

Second, West and Zimmerman made a strong claim that people do not play "roles" of men and women or enact their natural gendered selves, but rather do gender in interactions with others, they "…organize their various and manifold activities to reflect or express gender, and they are disposed to perceive the behaviour of others in a similar light." (West & Zimmerman, 1987, p. 127). It means that gender becomes an omnipresent category in people's lives and a category by which they are always held accountable. This accountability is inevitable as allocation of power and resources is based on one's sex category. In every social situation, however formal or neutral, one is expected to act in a way that is appropriate to their sex category. Failure to do so may lead to social reprimands of various severity.

However, as Butler (1990) argues, subversion of identity, destabilisation of the link between gender and sex category, "troubling" gender is a path to a more equal, genderless society as it demonstrates that in fact, there are no "natural" men and women and these categories are just performance and social constructs.

Hegemonic masculinity

Much research has been done, exploring the ways of how exactly gender is done by different social groups in different contexts. In light of my research, special attention should be paid to studies of masculinities and specifically to the concept of hegemonic masculinity proposed by Connell (1995). This concept

theorised on how men do their gender in a way that their practices of doing it allow their dominance over women. It was proposed that in one given society among masculinities one normative – hegemonic – form of masculinity exists which possess the qualities that a man needs to have in order to be considered powerful, successful, and "real" man in this society. Connell highlighted that these hegemonic masculinities rarely occur in real men but are rather constructed ideals reinforced by media, political forces, and discourse.

Importantly to this theory, the hegemony of this type of masculinity is established not by force but by culture, institutions, and discourse. Other masculinities exist in a hierarchy to the hegemonic one, as subordinated (e.g. gay man) or complicit (e.g. white-collar employees) ones, with the hegemonic masculinity at the top of the hierarchy. However, power relations between different types of masculinities and femininities are more complex than a simple hierarchy with all masculinities on its top and all femininities on the bottom. Besides, further research demonstrated that hegemonic masculinity changes over time and incorporates components of complicit and even subordinate ones. Local, regional, and global contexts also produce different, though interconnected, hegemonic masculinities (Connell & Messerschmidt, 2005).

Structural turn

Development of sex-role theory critique gave birth not only to "doing gender" theories but also to structural approach that analysed social structures in which inequalities occurred. Conceptually, researchers of this stream argued that "men and women behave differently because they fill different positions in institutional settings, work organizations, or families." (Risman, 1998, p.19). They argued that things that make women different from men are results of flaws in the systems and lack of opportunity, and not of lack of ability or psychological peculiarities (Epstein, 1988). They also argued that men, placed in the same disadvantaged positions within these structures, will also experience inequality and discrimination.

Special attention was paid to the analysis of workplaces. Kanter (1977) (whose theory will be discussed in details later on) demonstrated that similarly disadvantaged positions within work settings and restriction on access to social networks led to similar behaviours in men and women who found themselves in these positions, whereas feminine and masculine work styles had nothing to do with it.

Risman (1987) and Gerson (1985) also demonstrated that in personal settings, circumstances and structures like labour market, marriage, or parenthood in which people found themselves every day were more important to their choices and behaviours than their socialisation or psychological traits.

However, neither research on work settings, nor private life proved that gender inequality was solely a result of flaws in the way that these structures were built. In other words, gender-neutrality, that was at the core of structural theories, was

proved to not exist, as a simple change of place within structures did not lead to the same outcomes for women as to men (and vice versa). Thus, a new, integrative theory was needed.

1.1.2. Integrative paradigm: Gender as social structure

General outline of gender as a structure

The need for an integrative theory about gender was not a result of the inadequacy of the existing theories or some proof of their failure but rather a growing understanding of the complexity of the subject and a need for a paradigm that would have a greater explanatory power. Thus, an integrative theory was an attempt to draw connections between existing theories that operate on different levels of analysis. Several authors worked towards this goal (e.g. Lorber, 1994; Martin, 2004), however, for the purposes of theoretical consistency of my study, I will use formulations and conceptualisation suggested by Barbara J. Risman in her earlier (1998, 2004) as well as later (2018) works – "gender as a social structure".

The choice of the term "structure" is not accidental. By operating with it, she puts gender at the core of the society's organisation, in the same line as economic and political structures. As other structures, gender structure exists outside of an individual's control but has a direct influence on one's life. On the level of institutions and social interactions, it constrains one's actions through direct restrictions or subtle social control. It also shapes our identities and ideas about social reality through construction of imagined possibilities. However, for the structure to exist, an actor's choice how to act must exist as well. And although actors' possibilities are shaped by the structure, they do operate within their own interests.

Building on Burt (1982), Risman (1998, 2004, 2018) argues that norms and sense of one's privilege or disadvantage develop when "similarly situated" (Risman, 2018, p.30) actors compare their opportunities. However, because in our society biological sex is used as a demarcation line between people, men and women do not see each other as "similarly situated" and thus do not compare their situation to that of people of other sex. That is why the system does not look unequal to them. This demonstrates that gender is indeed a deeply embedded structure as it is present not just on the level of institutions and social interactions but on the level of individual selves as well.

It might seem that gender structure in this theory is rigid as it constrains us in every aspect of our lives, however, Risman puts special emphasis on recursiveness between the structure and individuals' actions. Referring to Giddens's (1984) structuration theory, she argues that actors are reflexive of their actions and thus they can act on the very same structures that constrain them. "Actions alter the world we have entered; institutions are powerful but not determinative." (Risman, 2018, p. 31). Here lies another strength of the concept of gender as structure, as it allows us to see not just how the system influences

people but also how people shape it – reinforce, change, or comply with it. This approach helps us to find these "cracks" in the fabric of reality that allow for change to happen and more equal gender system to emerge.

Another aspect that makes the integrative theory a powerful tool to study gender is that it does not contradict intersectionality that has become a leading paradigm in gender studies. The presumed universality of experiences of white and middle-class women was a subject of well-grounded criticism (e.g. Crenshaw, 1989; King, 1988). Research (e.g. Collins, 2000, Wilkins, 2012) demonstrated that indeed "various axes of domination are always intersecting" (Risman, 2004, p. 443) and not taking into account race, class, sexuality, etc. whilst studying inequalities means to ignore and silence people who are positioned on these intersections and contribute to their oppression. However, Risman (2004) argues, these various systems that produce inequalities (e.g. race, class, etc.) "are not necessarily produced or re-created with identical social processes". Thus, whilst always accounting for other axes, gender can and should be studied through its own integrative lens.

Operationalisation of the framework

To implement her integrative theory, Risman (2018) proposes to operationalise gender as a structure through three-dimension analysis with each of the dimensions having its cultural processes and material conditions. Three dimensions include individual level, interactional level, and macro level which are deeply interconnected and must not be studied as separate causes for whatever gender-related issue.

Individual dimension of analysis refers to questions of our internalised gendered selves. The research demonstrated that socialisation leads to internalising gender norms and behaviours, however, it has also shown that this internalisation is not always successful, neither permanent nor fixed. Gender structure streams biological boys and girls into masculine men and feminine women through expectations and institutions but they do not necessarily become or stay men and women by their identities. People develop different gendered selves, however, structure defines what do they "put" in their identities as we cannot escape imagined possibilities offered by the structure.

The cultural aspect of this dimension is represented by the analysis of how cultural ideologies and ideas about masculine and feminine become our internalised masculine and feminine selves which we maintain and adapt though our lives as these ideologies and ideas change. The material reality in this dimension is our bodies, that we choose or reject to fit according to the gendered expectations. The embodiment of our identities is directly influenced by institutions and ideologies but also by other people's gazes.

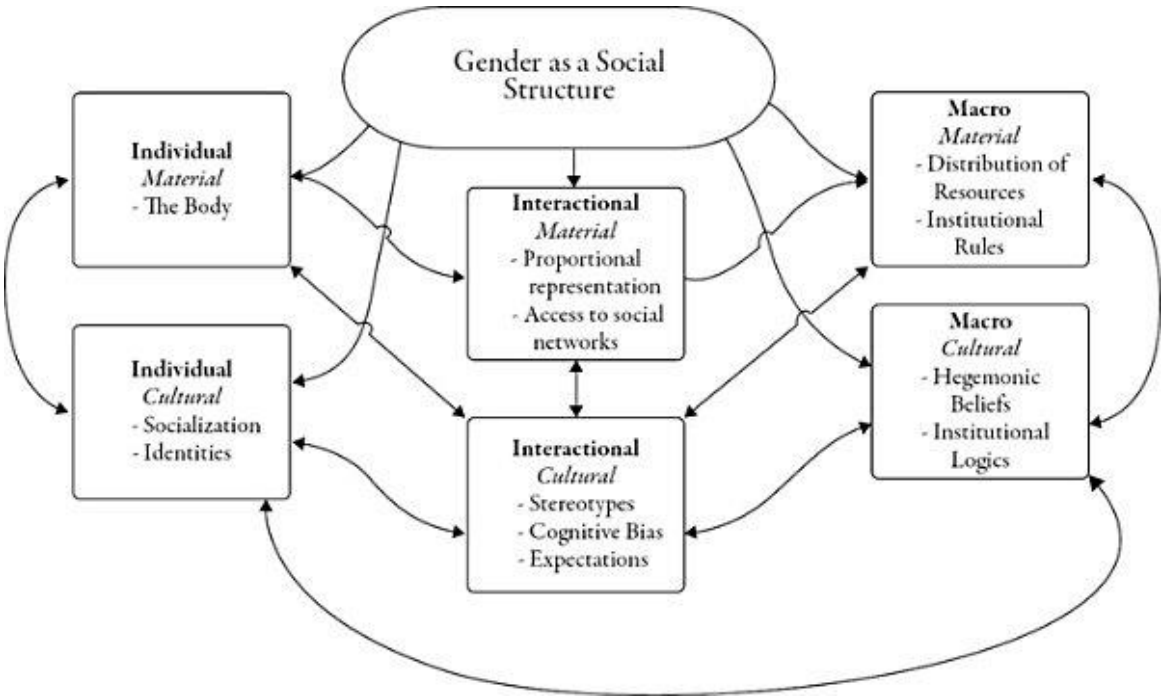
The interactional dimension of analysis includes gendered expectations that others have about us and we have about others. It is the accountability of doing gender in any and every situation of our life. That is also a dimension on which inequalities become more visible as we do not stop doing gender and do not

stop being accountable for it when we enter settings in which resources and power are distributed. The cultural aspect is especially strong here as expectations that accompany our interactions are shaped by culture and stereotypes that are specific to the society we live in. Cognitive bias that we "inherit" from cultural ideologies influence both our identities – for example, whether we want to be engineers or nurses – and our opportunities – whether we are assessed fairly and equally on interviews. The material reality of the interactional dimension is represented by proportional representation of different gender groups and social networks integration that such proportion entails.

The macro level of analysis consists of ways how gender shapes social institutions, organisations, and other structures. It is a level on which inequalities are institutionalised and have a direct influence on people's lives by imposing formal constraints on them. The ultimate form of such institutionalisation are laws that represent a material reality of this dimension. However, even when laws prohibit discrimination, organisations and institutions do not become gender-neutral, as they have an embedded cultural logic according to which they allocate power and resources. This logic does not come from nowhere but stems from stereotypes, believes, and ideology, thus shaping not just our real opportunities but also the world of our imagined possibilities.

The interconnectedness of all the described dimensions is best demonstrated in Figure 1. It is important to note, that list of processes described above and in this figure is not exhaustive and only gives an outline of how gender functions as a structure. Further empirical research can help to enrich this list by uncovering what is hidden from us under the cover of gender routine.

Figure 1. *Gender as a Social Structure Model of Gender as Structure*



Note. Figure Source: p. 33. Risman, B. J. (2018). *Where the Millennials Will Take Us: A New Generation Wrestles with the Gender Structure*. Oxford University Press.

1.2. Gender and labour

In this part of my study I would like to analyse the existing literature on the topic of connections that exist between gender and labour. First, studies that investigate gender segregation of the labour market will be discussed. Second, I will present studies that analyse experiences of people whose gender group is underrepresented in working environments. Further, I will discuss issues that are specific to men when they find themselves in these minorities. Afterwards, I will focus on the research about male nurses, and, finally, I will explore the literature on women surgeons. The studies that will be discussed in this section do not only come from sociological filed but also anthropology, social psychology, organisational studies, etc. Such multidisciplinarity will allow me to analyse the issue from various perspectives and draw a broader picture of the phenomenon.

1.2.1. Gender segregation of the labour market

As women's participation in the paid labour force had significantly increased, more questions about segregation of the labour market and its reasons rose. Epstein (1988) formulated the problem that this segregation entails: "at every level of experience and education women are concentrated in lower-level occupations and at lower ranks within occupations […] whatever stratum they are found in, women tend to cluster at the bottom". Such clustering leads to the situation when women are disproportionately presented in low-paid, low-status jobs (Blau & Kahn, 2017), and when they do enter more lucrative professions they are paid less and often hit "glass ceiling" in their career advancement (Williams, 2013).

The development of theorisation regarding the reasons for this phenomenon is somewhat similar to the development of theories regarding gender and gender differences. For instance, primarily, gender segregation of women into professions that require traditionally female characteristics such as nurturance and empathy and men into physically demanding and managerial jobs was explained by their natural propensity for such work (Epstein, 1988).

Further on, segregation was tried to be explained by the different ways in which men and women were socialised. As I have already described, research demonstrated that boys and girls are indeed placed in different environments and face different expectations regarding their behaviour, interests, and future success (e.g. Marini, 1978; Marks, 2008). However, the degree to which socialisation is determinative to future career choice is not clear as, first, there are obviously people who do choose non-traditional professions, and second, as was already discussed, gendered socialisation in childhood does not leave people with a fixed set of personality traits, skills, and preferences that do not change further in life under external circumstances (Reskin & Hartmann, 1986).

Another explanation of reasons that drive gender segregation of the labour market that has won significant acceptance is a human capital theory derived from the neoclassical economic paradigm. According to this theory, people are

driven by attempts to maximise their utility when making economic-related decisions, including one of professional choice. An important (and the most criticised) assumption that this theory allows is that all actors of the labour market are free in their choices, all range of existing opportunities is open to them, and the labour market is driven solely by the free competition (Epstein, 1988). Mincer and Polachek (1974, 1978) theorised that when making career choices women are driven by the assumption that they will become mothers and leave their jobs to take care of children. In the light of this foresight, there is little sense in investing in specialised training that would lead to a career that does not allow for maternity leaves, hours flexibility, and that requires accumulation of uninterrupted experience to stay competent. However, Blau and Jusenius (1976) argued that there are also male-dominated jobs (mostly blue-collar ones) that do not require extensive training and that would fit women's requirements about flexibility and breaks in career, but women do not enter them in significant numbers and these professions remain male-dominated. Reskin and Hartmann (1986) also questioned the very assumption that in their career choices women are driven by their commitment to future maternity.

Following the structural turn, Bibb and Form (1977) suggested that it is not individually "low" human capital of women that leads to their segregation in lower paid, less prestigious jobs, but rather their high presence in what they called peripheral industries – industries in which firms are small, have few resources and are labour intensive. In contrast to core industries, where large companies benefit from economies of scale and earn stable profits, as well as their workers who enjoy higher salaries than those on the periphery. Beck and colleagues (1980) however pointed out that women are also represented in core industries but mostly on clerical positions which leads to significant pay differences between men and women within core industries.

Another remarkable structuralist theorising attempted to explain gender segregation of the labour market through Marxist tradition. Women's position of an unpaid domestic labour force and their crucial role in the reproduction of paid labour force suggested some similarity to the position of the oppressed working class in the classic Marxist theory. Thus, Marxist-Feminists argued, that women position was defined by two systems of oppression – capitalism and patriarchy. The latter was theorised as either result of male control over women's reproduction and sexuality (Firestone, 1970) or as an attempt of men to preserve their dominant economic position inherent from preindustrial times through denying women's entrance into the most prestigious fields (Hartmann, 1976).

Although somewhat less radical than Marxist-Feminist stance, other researchers also did account that women's disadvantaged position on the labour market is caused to a certain extent by discrimination. Epstein (1988, pp. 149-151) demonstrated that throughout history women's advancement in various lucrative fields, such as medicine or law, always encountered resistance from the side of men who were already employed in the field and who reasoned their opposition by their concerns over their own employability, customers' distaste to women providing services to them, and even fear of the decline of the nation.

Although a wage gap has been decreasing over the last years (Blau & Kahn, 2017) and legislation in many countries does forbid any forms of discrimination, gender segregation of labour market persists. Thus, people who decide to cross this gender boundary between professions, pose an interesting case that might help to better understand the problem and ways to mediate it.

1.2.2. Studying people in non-traditional professions

Token theory and its critique

One of the first approaches that was adopted to understand and conceptualise experiences of people working in non-traditional professions was the concept of "tokens" proposed by Kanter in 1977 in her book *Men and Women of the Corporation*. On the example of one Fortune 500 firm, she studied the effects that being an underrepresented minority had on work-related experiences of people in this minority. She conceptualised underrepresentation as a situation where minority – tokens – comprise less than 15% of the work group. In her book saleswomen were such tokens, however, Kanter argued that any group that is a token in the organisation (e.g. in terms of being a racial or religious minority) would have similar experiences as these saleswomen had, thus, from her viewpoint, it was not their gender that affected them but rather a situation where the proportion was severely skewed.

Among the consequences that Kanter attributed to being tokens were three effects: "visibility, contrast, and assimilation" (in Gustafson, 2008, p.2). Visibility meant that saleswomen became known within the company simply because they stood out demographically but not necessarily for their professional characteristics. It created additional pressures as both their successes and mistakes were subjects of close scrutiny, their actions were considered to have symbolic meaning as if they were representatives of their minority group and not just individuals. And most importantly, women felt that they had to perform better than men to be accepted and recognised professionally, but at the same time not to perform "too well" in order to not threaten the dominant group.

Contrast meant that the presence of tokens encouraged the dominant group to highlight cultural differences that existed between two groups, especially in informal settings. This heightening of the boundaries left women with a choice between two strategies: to be a silent audience and isolate themselves by a symbolic comfortable distance from men at the cost of participation in behind-the-curtains politics, or to be included by demonstrating loyalty to the dominant group and occasionally turning against other women either symbolically or even through performing a gatekeeper role and obstructing other women's career development.

And finally, assimilation meant that tokens were tended to be encapsulated in stereotypical roles that dominant group was placing upon them depending on the behaviour the tokens adopted. Being limited by these roles, saleswomen could not escape the stereotype and were bound to play by the established rules which limited their chances of advancement, isolated them, or left powerless

even in managerial positions. Another important dynamic that Kanter found was status levelling when, first, saleswomen were initially mistaken for workers of traditionally female jobs such as assistants or secretaries, and even when situations were clarified they would still be treated as hybrids of their real and expected roles, being asked to perform tasks that would not be asked from a man (e.g. bringing coffee).

Kanter's theorising received high acceptance with a significant amount of research stemming from her token concept. Some examined experiences of women in other male-dominated fields like army, academia, police, STEM, high management, etc. Other tested the theory on racial minorities in police, army, and management. And then there were studies of men, employed in female-dominated spheres like social care, clerical work, nursing, and some other. For a detailed list of the existing studies in these fields see Gustafson, 2008, p.4.

As the body of research on tokenism grew, it started to receive a well-grounded criticism. One of the major issues that was argued was the Kanter's focus on the numerical proportion of the token group and the intentional overlook of their social group membership such as being man or woman, black or white, etc. Empirical evidence challenged such focus, demonstrating that tokens that belonged to socially higher-status groups did not face the consequences of their token status as described by Kanter (Yoder, 1991). The connection between status and negative consequences for tokens were explored through a study conducted by Yoder et al. (1998) in which women were minorities but their status was elevated by additional training (thus, their competence was more credible in the eyes of the dominant group) and legitimisation by a credible source. Results of this and similar studies (e.g. McDonald et al., 2004, Fairhurst & Snavely, 1983) demonstrated that it was rather status than numerical proportion or gender per se that related to negative experiences of women.

However, it is important to keep in mind that, as it was previously discussed, gender (as well as race) is an omnipresent characteristic and in contemporary society women (as well as people of colour) are ascribed lower social status than men (McDonald et al., 2004). It explains why in token situations it was almost always women (or black, Hispanic, and other minorities) who faced consequences but rarely men (or white people). In her critique of Kanter's token theory Zimmer (1988) wrote: "In a racist society, race-neutral theories of race relations make little sense. And in a sexist society, gender-neutral theories of organizational behaviour may mask rather than explain reality." (Zimmer, 1988, p. 71)

Another overlooked issue that was criticised in the token theory was gender inappropriateness of the job of the studied group. According to Laws (1975), women aspiring to build a career in a male-dominated sphere (as in Kanter's work) were double deviants in terms that both their goal itself and their choice of the professional field challenged the gender norms. Thus, Yoder (1991) argued, it was likely that such disposition had an additional negative influence on these women's experiences besides their small numbers and low status entailed by gender. This statement was to somewhat extent supported by studies that focused on the perception of women working in stereotypically "male" professions. Yoder and Schleicher (1996) and Heilman et al. (1995)

concluded that women employed in such occupations are viewed more negatively regarding their interpersonal characteristics but men do not face similarly negative judgements. Heilman (2001) argued that women who violate descriptive and prescriptive stereotypes in terms of their career choices or working behaviour strategies, face devaluation of their achievements, lack of recognition, personal derogation, and dislike.

Although tokenism theory did indeed focus on the numerical representation of the minority, it is possible that it was not just small numbers of women in the working group that led to the abovementioned consequences but rather a growth of these numbers. Blalock (1967) argued that high-status groups feel threatened by such advances of low-status groups and react by attempting to limit access to power and resources. And as professions in which men numerically and symbolically dominate, professions that are "appropriate" to men are generally better paid and associated with higher prestige than "women's" jobs (Cejka & Eagly, 1999), men are more interested in preserving their status quo than women (Gustafson, 2008). In the study of policewomen and male nurses Ott (1989) found that when female minority increases in numbers "[t]he attitude of the male majority changes from neutral to resistant, whereas the attitude of the female majority changes from favourable to neutral. In other words, men increasingly want to keep their domain for themselves, while women remain willing to share their domain with men." (Ott, 1989, p.53)

Although the critique of the tokenism theory is substantial, it still can be used for the analysis of underrepresented minorities in different professions if enough attention is paid to the context and power relations existing beyond the numerical dynamics. For that additional theorising and empirical evidence is required. One of such concepts that has proved to be fruitful in this field is one of the "glass escalator".

"Glass escalator" and masculinities

The term first was proposed by Williams (1992) in her research on the experiences of men in such female-dominated professions as nursing, elementary school teaching, librarianship, and social work. She conducted in-depth interviews and discovered that in contrary to "glass ceiling" that women experience when climbing the career ladder, men encounter a "glass escalator": "Often, despite their intentions, they face invisible pressures to move up in their professions. As if on a moving escalator, they must work to stay in place." (Williams, 1992, p. 256). It was so, she argued, because it was viewed by managers that administrative, more "masculine" specialities within the profession were more suitable places for men. Commonly, these positions were those that were better paid and vested men with more power. Thus, men were pushed up the career ladders. The negative stereotypes such as being seen as "feminine", "passive" or "gay" also pushed men to leave the most "female" areas and "head up". Besides, Williams found that although men were excluded from some informal socialisation that happened between female workers and

experienced discrepant treatment compared them, they characterised this difference as positive, a situation very different from this of women in male-dominated spheres.

Further research confirmed and extended Williams's findings of men's advantages in female-dominated jobs: Maume (1999) showed that white men have more chances to get promoted and it happens faster than with black and white women, and black men; on quantitative data Budig (2002) demonstrated that men are advantaged in terms of pay and promotion both when they are tokens, dominant or numerically equal group; Smith (2012) found that in settings where employees report to minority or women, pay gap between minorities or women and white men increases as a person moves up the career ladder.

However, the "glass escalator" concept was also criticised by different researches and Williams herself. In 2013 she wrote that initially her theory did not account for other statuses – race/ethnicity, sexual orientation, class, etc – although further research demonstrated the crucial importance of those on occurrences of "glass escalator" effect. Besides, she drew attention to the transformation of the workplace that had happened since she introduced her concept and suggested that it is no longer relevant in neo-liberalised, unstable, and flattened labour market structure. Although the latter seems to be well-grounded for the spheres that have undergone the biggest change, nursing in the United Kingdom and the Republic of Ireland, that will be investigated in my study as a male-dominated profession, still remains public sphere with clearly outlined hierarchy and relatively high stability. Thus, I consider "glass escalator" to be a still-relevant concept for my research.

Besides the "glass escalator" concept, other issues that men face in female-dominated professions were studied. Among those are the ways which lead men to these professions. Williams and Villemez (1993) proposed and then Simpson (2005) found support for typology, according to which there were "seekers" (men who actively choose the career), "finders" (who found themselves in it accidentally), and "settlers" (who entered female-dominated professions after leaving some male-dominated field). It was found that "settlers" were actually the group who struggled with the "glass escalator" effect as they were interested in the profession itself rather than in administrative roles within it.

Simpson (2004) also tested three consequences of tokenism from Kanter's theory: visibility, contrast, and assimilation and found that although men did experience them, they resulted mostly in positive outcomes for their careers. Visibility brought faster career growth, better reward (supporting studies were discussed earlier), and "assumed authority effect" (Simpson, 2004, p. 362) when men were more often placed in situations where they could be authoritative and assertive which was beneficial to their career development. Contrast was rather a result of the intentional distancing from the dominant group and its feminine features which led to higher status but not marginalization as in case of token women. Assimilation suggested several roles to men to which they could conform such as of a "father", "son", and "muscle-man", however not falling into one of them was not as heavily penalised as in women.

Moreover, masculinities and "gender work" of men working in female-dominated professions were studied. Lupton (2000) and Cross and Bagilhole (2002) found that men adopt different strategies to cope with challenges to their masculinities, questioning of their sexuality, and stigma of effeminate or gay men: they engage in reformulating their professions, emphasising its masculine aspects or masculine traits of their personalities or attitudes to the job; distance themselves from female colleagues; or construct new masculine identities that incorporate feminine characteristics of their occupations. These strategies become more utilised when other men scrutinise masculinities of men working in women's jobs and become less of necessity around other women and private selves (Kimmel, 1994).

These are the key concepts which I will use in my study and which are essential for the analysis of the experiences of people working in non-traditional professions. Further in this chapter I will present a more detailed literature review on male nurses and female surgeons.

1.2.3. Previous research on men in nursing

Research on men in nursing has been an integral part of studies that prove, criticise, or simply use the abovementioned concepts of tokens and "glass escalator". Thus, this body of research focuses mainly on individual experiences of male nurses, analysing obstacles and advantages that they encounter in their professional lives and discovering their identity formulation practises (Cottingham, 2019).

"Glass escalator" in nursing and building masculine identities

A significant body of research argues that male nurses find themselves advantaged towards their female colleagues in numerous ways. As was already described, based on their gender status, men are presumed to be more competent, authoritative, ambitious, and bold, they are often mistaken for doctors by patients and visitors (Floge & Merrill, 1986, Cottingham et al., 2018). Presumptions about their professional competence come not only from the management but also from colleagues, doctors, and patients (Floge et al., 1986). Due to the "glass escalator" effect, it is often that the managers of male nurses are also men which makes their relationship more confidential and egalitarian than those that women have with these male managers (Williams, 1992).

It is also often that male nurses distance themselves from female colleagues and have closer personal contact with other men in the hospital – doctors and managers, which can positively contribute to their career development (Floge et al., 1986, Floge & Merrill, 1986). This distancing sometimes is a result of the intentional exclusion of men from group activities and talks but often it is a strategy that men themselves choose to construct their masculinities in opposition to "typically feminine" topics and behaviours. They claim they have no interest in discussing such things as fashion or children and emphasise

technical and scientific side of their jobs rather than its emphatic and nurturing aspects. Heikes (1991) suggests that it might be a boundary heightening technique which men adopt to maintain their higher social status which is dictated by their gender. Thus, their token experiences are reversed versus those that women have in male-dominated professions.

However, masculinity studies demonstrate that reinforcement of masculinity is not the only strategy of building an identity of self that men in female jobs adopt. As Pullen and Simpson (2009) write, men also create "projects of femininity" in which they distance themselves from hegemonic masculinity and normalise feminine sides of their personalities, affirming that men can be nurturing, empathic, and caring. Authors argue though, that such identity formulation does not mean undoing masculinity altogether but rather mean positioning oneself in relation to hegemonic masculinity, thus accepting its dominance, and claiming their "right" to certain aspects of femininity, validating these aspects by incorporating them in their still masculine identities. Besides, Pullen and Simpson (2009) and Evans (2002) draw attention to bodily experiences of male nurses, how their touch brings different, more sexualised and threatening air than "safe" touch of a female nurse and how men learn to employ different bodily strategies in different situations with patients.

Besides faster career growth, men enjoy higher payments due to both wage gap and specialities segregation (Budig, 2002). The latter usually means that men are more represented in managerial positions and such areas as psychiatry and emergency. These areas are considered to be more masculine as they include more masculine duties such as dealing with violence and aggression and reacting in a fast and decisive way. As it often happens with different fields in which men are more present, these specialities are also better paid (Snyder & Green, 2008).

Another task within nursing that is also associated with masculine traits is heavy patients lifting (Keogh & O'Lynn, 2007). Due to their perceived strength, men are usually asked and expected to do the lifting, thus encapsulating themselves in a role of a "muscle men", however, some male nurses treat such duty acceptingly as these are the brief moments when they do not experience role conflict – a situation when their masculinity is at conflict with feminine demands of the profession (Heikes, 1991). Besides, because of the presumption that men are less emotional and more detached, male nurses are not expected to perform emotional labour in the same way and amount as female nurses and when they do perform it, it brings them bonuses in the form of higher job satisfaction and less intention to turnover than is observed in female nurses who often experience burnout because of the constant strain to do and/or perform emotional labour (Cottingham et al., 2015).

Problems of male nurses

Coming to the problems that men face in nursing it is important to outline the issue connected to care that male nurses provide to female patients. Student nurses report that they are being excluded and strongly discouraged to pursue

a career in such areas as obstetrics and midwifery (Keogh & O'Lynn, 2007). Besides, they feel that they are less educated to provide intimate care to women and often are not allowed to learn and practise these skills (Kouta & Kaite, 2011). It is, however, in contrast to women who experience no restriction in providing care of any sort to men. Researchers highlight that it is often colleagues and supervisors who exclude male nurses from women care, often due to legalistic concerns (e.g. not to be accused of sexual assault) and rarely patients themselves (Keogh & O'Lynn, 2007) (although patients do have right to choose not to be cared by men which male nurses consider normal and not discriminative (Rajacich et al., 2013)).

Another group of studies is dedicated to male nurses accounts regarding reasons why men are underrepresented in the field and what issues they face in education. Thus, it was found that men connect their token status in nursing to negative stereotypes about male nurses, profession's feminine image, experiences of not being accepted by female colleagues (Roth JE & Coleman CL, 2008, McLaughlin et al., 2010), and lack of role models and representation in the history of nursing (Rajacich et al., 2013). The latter was also named as a problem for male nursing students, along with gender-biased language, and discriminatory remarks from educators (O'Lynn, 2004).

Profession's feminine image and negative stereotypes about male nurses are especially influential factors for men in nursing. Male nurses are seen as effeminate and/or gay (Jinks & Bradley, 2004) and even male nurses themselves feel that they follow more female gender norms than the male ones (Loughrey, 2008). Public images of male nurses and their representation in popular culture also adhere to the stereotype of men in nursing as of someone lacking intelligence ("failed medical student applicant", lacking masculine attributes ("gay/effeminate"), being odd ("misfit"), or sexual predator ("womanizer") (Burton & Misener, 2007). Such narrow and inaccurate representation enhances the stereotype which deters men from nursing and creates a role conflict in men who are occupied in this profession (Weaver et al., 2014).

For male nurses role conflict is especially detrimental: experiencing role conflict decreases male nurses' job satisfaction (that is generally lower than in women nurses (Sochalski, 2002)), causes them to leave the workplace or profession altogether and accounts for a significant amount of job stress and consequential occupational burnout that might decrease quality of provided care and contribute to attrition and high turnover in nursing (Hsu et al., 2010).

However, as Cottingham (2019) points out, contemporary research on male nurses often constructs men in nursing as missing, basing the discourse "…on appropriating de-contextualized rhetoric of gender equality and diversity from oppressed groups. This rhetoric strategically places nursing's missing men alongside other politically relevant debates concerning the exclusion of minorities in otherwise homogenous professions, including the exclusion of people of colour and women from the fields of science and medicine. Within professional nursing texts, the absence of men is constructed as a social rather than an individual problem. Men's documented advantages receive limited attention and, when acknowledged, are relegated to the realm of the individual.

The ‘problem’ of gender inequality in nursing appears predominately as the problem of men's experience of prejudice and discrimination as a numerical minority. Nursing texts subtly reassert an old binary that relegates ‘women's problems’ to the private realm and men's to the public realm.” (p.208)

To sum up, the literature review presented above, I would like to note that male nurses studies have a long-running tradition and are indeed diverse. Researches have implemented various methods to investigate different aspects of male nurses’ experiences and there is a significant representation of different national contexts, including the United Kingdom and the Republic of Ireland. However, there seems to be a fragmentation of topics across different studies and disciplines, thus I will try to compound them in a broader picture in my research.

1.2.4. Previous research on women in surgery

Analysis of women surgeons forms an integral part of the body of research on women in male-dominated professions, however, it has its own specificities and limitations. Primarily, I would like to highlight that the majority of studies concerns the case of the United States, deriving from the data collected there, and is guided by the local healthcare system environments and culture. Secondly, the majority of studies employs quantitative methods of research addressing quite particular inquiries in an attempt to provide an objective view on different issues, which sometimes leads to a situation in which narratives and voices of women surgeons are lacking from the research.

Studies on women surgeons explore several central topics, most of which are important to policymaking and often call for action regarding the issues they investigate. The crucial institutional problems that these studies are trying to address are attracting medical students to surgery and retaining them in the profession. As research identifies women as a potential and prospective workforce that is underrepresented in the field, a lot of studies address issues that are specific to women’s experiences in the field or have more influence on them. Although, as to the author’s knowledge, there are no studies that would adopt token theory explicitly, a lot of findings do correspond with the consequences of tokenism outlined by Kanter (1977).

Gender discrimination

The first issue that is considered regarding women in surgery is gender discrimination. In Peel et al., 2018 literature review on the topic, authors place gender discrimination as one of the most researched and important causes that contribute to low numbers of female doctors entering surgical trainings. It occurs on all levels of training, starting as early as medical school and continues throughout the all career hierarchy (Seemann et al., 2016), in all specialities (Dresler et al., 1996) and settings (Bellini et al., 2019). It comes from both male and female surgical and nursing staff (Ferris et al., 1996) and takes all forms from inappropriate language and comments to recruitment decisions taken

based on gender bias, and even includes cases of sexual harassment (Bruce et al., 2015). Experiences of discrimination (or observing and even hearing rumours about such occurrences) not only deter women from entering surgery (Stratton et al., 2005) and contribute to their decisions to quit the profession altogether (Liang et al., 2019) but also decrease their job satisfaction and perceived self-efficacy, cause higher levels of stress and contribute to professional burnout (Bruce et al., 2015). Some studies demonstrate that women believe that gender discrimination impedes their career development (Dresler et al., 1996) and there is a substantial body of research (see Zhuge et al., 2011 for literature review, Abelson et al., 2016) that confirms that gender discrimination remains one of the major factors that contributes to the "glass ceiling" phenomenon, however evidence to the opposite is also present (Ferris et al., 1996). Nevertheless, there is consistency in opinion regarding gender pay gap that continues to exist in various surgical specialities (Zutshi et al., 2010, Dresler et al., 1996, Yutzie et al., 2005, Halperin et al., 2010, Grandis et al., 2004)

Although more visible occurrences of gender discrimination are still not rare in the field, less obvious issues are also discussed in various research. These issues include: (a) implicit bias (Davids et al., 2019, Zhuge et al., 2011) – situations when women are (often unintentionally) treated differently or discriminated against due to unconscious perceptions about their traits, interests, priorities, and capabilities that arise from traditional role of women in the society and ideas about femininity (i.e. role encapsulation); (b) "hidden curriculum" (Orri et al., 2014, Jin et al., 2012, Gofton & Regehr, 2006) – attitudes, beliefs, and behaviours that are passed from mentors to their mentees and often include stereotypes and prejudice; (c) differences in confidence (Nomura et al., 2010), when women feel less confident due to greater psychological pressures of male-dominated environments and situations of inequity when they get less sufficient support than men (i.e. consequence of high visibility in the field); (d) double standards (Colletti et al., 2000) when women are evaluated by higher standards than man as they are more visible as tokens and negatively judged for behaviours that are praised in men (Bickel, 2011); (e) learning patterns, behaviours, and levels of self-esteem and their influence on female surgeons career development and experiences in the profession (Greenberg, 2017, Meyerson et al., 2017).

Lifestyle of a surgeon

The second issue that has a significant impact on women's career choice is a perception of the lifestyle of a surgeon and its (in)compatibility with family life. Studies discuss that surgeons (both men and women) are exposed to a high level of work-home conflict which leads to depressive symptoms and burnout (Dyrbye et al., 2011), decreased professional satisfaction and attrition from training, with women being more vulnerable to this factor (Yeo et al., 2018). Research also reports that women perceive surgery as being poorly satisfactory in terms of work-life balance which deters them from choosing it (Kerr et al., 2016, Sanfey et al., 2006, Caniano et al., 2004). A surgical lifestyle which includes long and unsocial hours and insufficient possibilities to work less than full-time have often been confirmed to be a significant barrier for women in

surgery (Bellini et al., 2019, Fitzgerald et al., 2013). However, women who do choose surgical career report high levels of job satisfaction (Ahmadiyeh et al., 2010, Yutzie et al., 2005, Halperin et al., 2010, Smith et al., 2006), greater than those reported by women in other specialities (Frank et al., 1998).

Another body of research focuses on the impact of marriage, pregnancy, and childcare on the professional life of surgeons. Women are reported to become more conscious about their performance after marriage and having a child increases levels of stress within them (Chen et al., 2013, Sandler et al., 2016). Besides, women report that they are afraid to face negative attitudes connected to their motherhood (and other research actually confirms that peers and senior colleagues indeed translate such attitudes (Turner et al., 2012)) and that they are being discouraged to have children during trainings. Those women who did encounter stigma during pregnancy, did not have formal maternity leave policy or changed their training plans due to childbearing experience, lower job satisfaction and were more likely to advise other women not to enter the surgical field (Rangel et al., 2018). However, studies demonstrate that number of women deciding not to postpone childbearing till after training increases (Turner et al., 2012) despite not being supported by their superiors and peers (Altieri et al., 2019), problems with institutionalising maternity leaves, too short maternity leaves allowed by the policies, and absence of lactation facilities that would facilitate transition periods and decrease stress within new mothers (Merchant et al., 2013, Turner et al., 2012).

Issue of role-models

The third issue that is discussed in the literature is the absence of same-gender role models. Some research says that not being able to identify with someone in the profession becomes a deterrent for female medical students from entering the surgery and continuing to progress in it (Ferris et al., 1996, Sanfey et al., 2006, Park et al., 2005). Within surgery, specialities that have higher proportions of women attract more female students (Smith et al., 2006). Hill and Vaughan propose analysis through the concept of “paradigmatic trajectories” in which they argue that women do not pursue a career in surgery because it lies outside their perception of possible professional development in which they would be able to fit in. Some studies also demonstrate that role models have the same importance in career choice and development for men as for women (Bongiovanni et al., 2015, Ravindra & Fitzgerald, 2011)

Related to that, the importance of positive exposure to surgical experience is discussed, demonstrating the increased interest in surgery after such exposure as well as through contact with female role-models (Williams & Cantillon, 2000, O’Connor, 2016). Besides, perceived diversity of a surgical training program seems to be another influential factor for women when they chose a surgical career as they anticipate their future position in non-diverse programs as being in the minority which can lead to typecasting by the majority, higher standards of judgement, decrease in self-esteem, and loss of motivation (Ku et al., 2011).

In addition to that, studies outline that women surgeons feel less support during their surgical trainings than male trainees, to the level that it sometimes makes them quit their education altogether, although lack of mentorship and opportunities to discuss problems do affect male surgeons as well (Bongiovanni et al., 2015, Yeo et al., 2009).

Masculine stereotype about surgeons

The next issue that is strongly connected to the previous points is the image of the surgical profession in general and of a surgeon in particular. Remarkable anthropological research conducted by Cassell (1986, 1991, 1996, 1997, 1998) through participant observation and numerous interviews in unprecedented details uncovered what it meant and what it took to be a surgeon and to be a women surgeon in the US at the end of 80-s and 90-s. She described the culture and the temperaments that were admired, the myth and the ideals of this medical "old boys club", the rituals and the stereotypes that demonstrated the inherent masculine character of the profession – the reason why women were and still are wary to enter it. A lot of further research derive the images and perceptions that were presented in Cassell's works, confirming them and giving them new explanations (Orri et al., 2014). A somewhat similar analysis was conducted by Kelogg (2011) who performed an ethnographic study of surgeons in two hospitals in the United States and came to the conclusion that characteristics that are idealised in the surgical field remain the same and include being male, macho, individualistic and unconditionally dedicated to work. However, as to the author's knowledge, a comparably deep analysis of the British and/or Irish surgeons has not been conducted.

Nevertheless, there is an inquiry on female medical students identity that, though not particularly focusing on surgeons, gives an insight on how and why women learn to manage their gendered identities to fit into the professional identity, how fast they acculturate and become insensible to sexual harassment and discrimination from both patients and superiors to survive in the field, and how it influences their career decisions in the future (Babaria et al., 2012). Moreover, Hill et al. (2015) investigate competing discourses of being a woman and being a surgeon, their (in)compatibility, and tools that women use to navigate this discursive space and form or find their identities within it. The concern regarding praise of such masculine traits as physical strength, competitiveness, and aggression in surgery can "other" women within the field and hamper their development of a sense of belonging to the profession as they do not identify themselves with these characteristics (Moulton et al., 2013, Peters & Ryan, 2014, Jin et al., 2012, Peters et al., 2012) thus isolating them through highlighted contrast to the dominant group – male surgeons.

Besides, studies investigate the influence that such masculine professional culture has on choices that medical students make when choosing a future speciality. Women often perceive surgery as being particularly not welcoming to them because of its "old boy club" culture and negative attitudes to women that stem from it (Fitzgerald et al., 2013, Bucknall & Pynsent, 2009, Gargiulo et al.,

2006). Specific “surgical personality”, especially its individualistic, “poor people skills” side deters not only women from pursuing a career in surgery but also men who do not conform to such hegemonic masculinity (Kozar et al., 2004).

Summarising the presented literature review, I would like to outline several gaps that I will try to address in my study. First, it will concern the context of the United Kingdom and the Republic of Ireland which has not been sufficiently represented in the existing literature. Second, I will adopt a qualitative methodology that (a) can help to identify issues and details that might have been overlooked in previous quantitative research; (b) follows the feminist tradition that allows enriching the study with people’s perspectives and researcher’s interpretations which is impossible to achieve through somewhat rigid assumptions of quantitative research that might have inherent gender bias (Liang et al., 2019).

2. Analysis of empirical data

2.1. Methodology of the empirical research

My choice of research tools to investigate the role of gender in experiences of female surgeons and male nurses was guided equally by two factors. Firstly, I needed to not only look into topics that were explored before and are traditionally associated with professional experiences of these groups but also try to discover new narratives that might have emerged in specific UK or Irish contexts and might have been overlooked before. Besides, even when investigating well-researched themes, my goal was to capture a detailed picture of people's experiences, to include its micro-level, its every-day manifestations, to give colour and voice to the researched problems. The second factor was driven by the theoretical approach of this research, as it uses the integrative paradigm that views gender as a social structure. Such theoretical model presupposes that people have their gendered selves and they do gender in accordance with certain rules that are not static and shaped by a multitude of different factors. To understand different dimensions of gender functioning as a structure a close-up approach was required.

Thus, I have chosen to conduct semi-structured in-depth individual Skype interviews with female surgeons and male nurses from the UK and the Republic of Ireland. The interview guide was created based on the previous findings in the field and initially consisted of three thematic blocks: education path, career path and relationship with colleagues, superiors, patients and "outsiders" (Appendix A). It included filter questions to understand what kind of experiences the participants had followed up by open-end questions to allow them to elaborate on topics they were asked about. Besides, at the beginning of each block participants were asked broad, descriptive questions, for example, "How would you describe your educational experience?" to allow them to outline topics that they considered important. The interview guide was similar for female surgeons and male nurses.

For this study I used purposive sampling with such criterion for women surgeons as being a female medical student or qualified doctor with some surgical rotations experience and aspiration to become a surgeon; OR being a surgical trainee; OR being a consultant; OR being retired after a career in surgery. For male nurses, the criterion was being a nurse student; OR being a registered nurse; OR being retired after a career in nursing. The universal criterion was that participants must have had the relevant experiences in the UK or/and the Republic of Ireland.

Due to lack of access to the field and gatekeepers, I used social media to recruit interviewees. As a first step, I placed a call for participants on my personal Facebook and Twitter pages. The call briefly described the goal of my research and the criteria under which I was selecting participants. Two visual posters were attached to the publication. The Facebook publication was reposted six times and collected several comments, however, it did not seem to reach the target audience. The publication on Twitter brought more success – it was reposted nineteen times by different medical specialists including female

surgeons and male nurses. Several people from the target group commented under the publication and offered their help either by participating or by tagging someone who might have been interested in participation. Besides, the call for participation was sent to two open and one private group of surgeons on Facebook that allowed publications by users. Two professional communities of female surgeons – SheMD and RCSI Association of Women Surgeons – were contacted with a request to place the call for participants on their pages, with the latter agreeing to help and posting the visual poster. One personal contact with a male nurse in Ireland was also used which led to a wide reach to this professional group as he posted the call for participation in a private support group for Irish nurses on Facebook.

The second step of recruitment included contacting potential participants on Twitter. I analysed Twitter accounts of subscribers of various professional communities which resulted in contacting 27 female surgeons and 47 male nurses. In general, I felt a positive response from people whom I was trying to recruit for the research: they were easily approached and interested in participation, women surgeons being especially eager to help.

Those who responded to my message and agreed to participate and those who approached me themselves were sent Information Sheets (Appendix C) and Consent Forms (Appendix B) which they were asked to sign. These Information Sheets described the research in more details and informed the participants that all information they share will be anonymised and kept confidential. By signing the Consent Form, they demonstrated their consent to participate. During the interview the amount of collected personal information was reduced to a minimum in order to increase the level of trust between interviewer and interviewee and create the feeling that they can confide in the researcher without any repercussions. Thus, only the name, the position in the hospital, the level of training and specialisation were asked.

In total, 8 women surgeons (six from the UK and two from the Republic of Ireland) and 7 men nurses (three from the UK and five from the Republic of Ireland) were interviewed. High diversity of participants was reached in terms of their level of training and specialisations. Regarding empirical data about female surgeons from the UK and male nurses from Ireland, this number of interviews was determined by reaching the point of saturation, whilst in case of female surgeons from Ireland and male nurses from the UK additional material was not obtained due to COVID-19 outbreak and time restraints that medical workers faced because of it.

After the first interview with a female surgeon the interview guide was modified: questions regarding stereotypes about the profession were added to form an additional, fourth, thematic block. Also, because of the flexibility of the method, some questions varied from one interview to another, some parts were omitted and others were investigated in more detail. For example, a doctor who had just applied for surgical training was asked various questions about the recruitment process, about her emotions and perceptions with regard to the selection process. However, no questions about promotion or changing jobs were asked as it would not have been relevant to her experiences.

Due to limited resources, the interviews were conducted via Skype, some of them with video communication and some with audio communication only. Although usage of telecommunication technologies does present certain issues for the researcher (e.g. technical issues, not clear non-verbal communication), ability to participate from any convenient place and at any convenient time was a significant advantage for the participants, especially considering tight schedules of medical workers.

On average one interview lasted 30 minutes, with the shortest being 15 minutes and the longest – 50 minutes. Overall, participants were open to the interviewer and shared their experiences willingly, sometimes even confiding private and tragic facts about their lives or views they might have perceived could be negatively judged. My disposition as a researcher included being a woman and being a young social sciences student, which seemed to be an advantage as it was probably easier for women to talk about gender-specific issues with someone who might have also encountered them and for men – to not stay on guard of their masculinity which might have been the case if the researcher was a man.

All the conducted interviews were recorded (with consent from the participants), transcribed verbatim and pseudonymised. The pseudonyms are presented in the Appendix D. The logic of pseudonymisation was to include the abbreviation of the profession (SG for surgeons, NS for nurses), informants' level of career advancement (student, recently qualified nurse, consultant, etc.), and the country for which most of their experiences are valid.

Further, transcripts were thematically coded, codes arising from both theoretical background of the study and narratives of the informants. Afterwards, codes' consistency across all fifteen interviews was checked, and codes were grouped in categories and subcategories, establishing the connections between the codes. The most indicative quotes were outlined for further illustration of the analysis. Based on the created code system, analysis was conducted.

The analysis of the empirical data is organised, firstly, by the gender groups (female surgeons and male nurses) and, secondly, by the structure of the interviews. As well as the interview guide it consists of three major topics: education and work experience, relationship with patients, colleagues, superiors, and "outsiders", and reflection on the stereotypes about the profession. Although these are the three different focal points of the research, it is important to analyse them altogether as they are characterised by strong connection and interdependence and sometimes are inseparable from each other. Besides, other topics such as, for example, maternity or sexual orientation are included in the analysis, as they rose from the narratives of the informants and thus were marked as important to the discussed problems. Where possible, the comparison between men's and women's experiences is made.

2.2. Women in male-dominated spheres: Surgery

2.2.1. Education and work experience

All the informants were asked to describe their educational and career paths, their experiences from medical schools, trainings, internships, and other parts of professional lives. Special focus was made on such turning points of their careers as the choice of profession and specialisation, changing workplaces, and recruitment processes. Some additional narratives that informants brought up are also included in this section: maternity, role models, changes in the healthcare system, etc.

Because of the specificity of medical education in general and its surgical track in particular, it is sometimes difficult to draw a line between experiences from education and from work as most of the medical schools integrate pre-clinical (theoretical) courses and clinical experiences within their curriculum from early stages of the programme (McArdle, 2020). Besides, next stages of education that lead to the position of Consultant in surgery include Foundation Training (FT 1-2, 2 years), Core surgical training (CT1-2, 2 years) and Speciality surgical training (ST3-8, 6 years) in the UK (Surgeon | Explore careers, n.d.) and Foundation Training (FT 1-2, 2 years), Intern Year (1 year), Core training in surgery (ST 1-2, 2 years) and Higher specialist training in surgery in Ireland (ST3-8, 6 years) (Surgery | Medical Careers for Ireland, n.d.). Although all of them are stages of education, they consist of rotations between different clinical settings during which trainees work as doctors (FT) and further – surgeons (CT, ST). Thus, further analysis will not try to differentiate between education and work experiences but rather conceptualise them as a whole.

Decision to become a surgeon: From personality traits to role-models

Chronologically, the first step to the career in surgery is the decision to become a surgeon. Some of the informants had their minds set from as early as school age – for example, one informant had some work experience in Orthopaedic department even before going to medical school, while others decided only after graduating from the university.

However, for the analysis it is more interesting to look into the reasons why these women chose this male-dominated field, whether they had doubts about their choices, and if so, what they were.

The first reason that was named was a positive experience of clinical placements in medical schools.

> Because I've had some good placements as part of my training with surgical teams, particularly orthopaedics. (SG2, Post-FT2, UK)

These “good” experiences usually included encouragement and support from the team,

> I was lucky to work with some people who were supportive of me doing surgery. (SG4, Consultant, UK)

as well as inspirational role models. This last bit is particularly important as absence of female role models is often considered to be a factor that deters women from choosing surgery as they do not see such career as a viable choice for them (Hill & Vaughan, 2013). The collected data is not consistent regarding this issue. Some women did indeed feel that they lacked female role models as there were not many women in surgery in the times when they were training or those women were personalities that informants did not really want or could aspire to. However, it did not avert them from becoming surgeons.

> …sometimes is that women can be a lot harder on women and less supportive of women which is “I wouldn't be someday like that”, I wouldn't identify with that or I wouldn't like to think that anybody would consider that I'm like that. (SG1, Consultant, Ireland)

Other informants reported that they, in fact, did have female role models who were inspirational enough to influence their choice of career and further becoming in the profession.

> I had, sort of, only three female consultant surgeons at obs [obstetrics] and gynae [gynaecology] in the hospital, one of who was my education supervisor. She was very inspiring, all of them were so experienced and that’s played a role as well […] to do something more surgical rather than … (SG4, Consultant, UK)

Besides, informants shared that their role models were not necessarily women and their example and guidance were encouraging enough for them to pursue surgical career anyway, a finding that is not widely discussed in the existing literature.

> Well, at the time I made a decision I didn’t really know any female surgeons, so they were male. But they were people that enjoyed their job and they were really good teachers and they were pretty inspirational (SG8, Consultant, UK)

The second reason for choosing surgery that was named was certain personality traits that informants characterised themselves with. For example, surgery as being a practical sphere or surgery as a profession where decisions have to be made quickly were listed as something that attracted these women to the career.

> …surgery fitted to my personality. I like to make decisions quickly and go on… (SG8, Consultant, UK)

Similar reasoning was also given when informants were explaining why they chose their particular specialisations. For example, one medical student aspiring for a career in plastic surgery noted that her personality matched better with the type of work surgeons of that speciality do.

> I'm someone who likes to focus on the details and take my time to make things perfect. So then as more suitable speciality would be something like ENT [Ear, nose and throat] or plastic. (SG7, 3-rd year medical student, UK)

However, that was not the only reason women were giving when trying to explain their choices. One of the surgeons attributed her pick of the speciality to the interpersonal relationship that one forms while doing rotations during the traineeship. The peculiarity of such answer is easily explained by specific Irish context where change between hospitals is not really possible due to high reputational risks and trainees are likely to return to the departments where they were training. Although the informant shared the opinion that there was no "real" difference between the departments besides the teams themselves, it is possible to suggest that the reputation and working climate might be of a greater value for the professionals than their preferences in the specialisation.

Another surgeon commented that due to the stereotype of surgery as of a "macho" profession (this stereotype will be discussed in details further on), it used to attract people who do "not hav[e] particularly strong people skills, [are] not particularly caring" (SG5, Post FT-2, UK). She pointed out that it is still the case now for certain specialities, like Orthopaedics, and her preference of such specialities as breast surgery or upper GI (Upper gastrointestinal) surgery was driven by the intention to avoid these "macho" specialisations where her communication skills would not be appreciated while she perceived that in the specialisations of her choice "your communication […] is so important, because you're really… what you say at that moment can change that family's relationship with that disease and that person dying potentially" (SG5, Post FT-2, UK).

The next important point that should be analysed is doubts women had when making their career choices. When asked, whether they had them or not, the majority of informants admitted that they indeed had some concerns. Some of them pointed out that their concerns were caused by the low presence of women in surgery and thus difficulty to find a suitable role model that would demonstrate that lifestyle of a surgeon is compatible with having a family life, an issue vastly discussed in the existing literature (e.g. Park et al., 2005)

> I mean there were very few role models in Ireland at that time so very few general surgery consultants would be female. (SG6, Consultant, Ireland)

However, it is important to note that when consultants who are practising now talk about lack of role models during first stages of education (medical school and FT1-2) when the career choices were made, they mean times of at least 8 years ago as surgical training takes a long period of time. The doctors who are currently at earlier stages of their careers do not point to this factor and, in fact, one consultant who supervises trainees says that it seems to her that currently women have fewer doubts regarding a surgical career as "they can see that it's achievable" (SG8, Consultant, UK). The same word another informant used saying that despite lack of female role models, presence of female peers made her feel that she could achieve her goal.

Another source of doubts that women mentioned were long hours that could potentially impede their family lives and make balancing career and maternity responsibilities impossible, which goes in line with previous research on female surgeons (e.g. Bellini et al., 2019, Fitzgerald et al., 2013).

> …at the time I was very worried about if I wanted children, will I be able to have children, whether it was compatible with having a family… (SG8, Consultant, UK)

And although it still worries the young surgeons as well, the same informant remarked that now "being a full-time doctor is not as bad as it used to be because the number of hours is less" (SG8, Consultant, UK). However, it is important to note that for career decision-making the perceived hardship and workload of the profession might be more relevant than an actual number of hours as "candidates" only have limited information and often rely on common knowledge rather than statistics (Kerr et al., 2016).

The described process of decision making regarding the future career and doubts that women have about surgery illustrates how the interactional and macro levels of gender as a social structure directly influence people's lives. Masculine culture of the surgical profession, low numbers of women in surgery, and lack of female role models appear as strongly intertwined factors that influence the decisions. However, at the same time, this seemingly rigid structure changes, due in no small part to the personal dedication of the individuals.

"Please, describe your experiences from education": From strong support to bullying

The next part of the analysis will be dedicated to the general characteristics that informants ascribe to their experiences during education. As I have already mentioned, some of them do not belong to medical schools or academia per se, actually, most of them refer to clinical experiences and training, however, I should follow the logic of the narratives of the informants who attributed them to the education process and the process of becoming a surgeon.

Remarkably, the range of experiences informants described is truly wide even within the narrative of one person. For example, one consultant recalls that she had "some people who were very positive and gave me opportunities", who were "were supportive of me doing surgery" (SG4, Consultant, UK), which falls on one side of the spectrum. And at the same time, she tells a story of bullying, misogyny, and questioning of her professionalism, which is clearly positioned on the opposite side of the experiences' scale.

> …I had other people who are nasty bullies. One particularly so, Matron in my training, and another consultant who I encountered in various different stages who, although he was a very good surgeon, he was vile, especially to women. (SG4, Consultant, UK)

> In obs [obstetrics] and gynae [gynaecology] the problem is there is a lot of bullying and misogyny coming from female midwives. I mean I was told to my face by one of the senior midwives that they didn't think women should be allowed to be doctors. (SG4, Consultant, UK)

Another issue that female surgeons face during their education is questioning of their choice of profession. Often it directly corresponds to the stereotype that surgery is a profession for men and that it requires such qualities as physical strength which is traditionally ascribed to masculinity.

> And one of the reasons people have sometimes … question doing Orthopaedics, is you're a girl, therefore you may be not so strong, you know. I'm quite tall for a girl, and I still get told you might not be very strong or tall enough. But my male colleagues who were small have never been questioned based on their size. (SG3, ST7, UK)

Some other words with which informants described their process of becoming surgeons would be "hard work" and "long way", however, these specificities did not seem to be gender-specific.

> …that's kind of as fast as you could progress through the system when I did it. And I didn't have a direct run through from basic surgical training to higher surgical training, most people did research, so I did research in the middle, so it was long but it was fine. (SG6, Consultant, Ireland)

Though, what was gender-specific, were the differences in learning patterns of men and women, noted on several occasions by different informants. Two consultants pointed out that in their trainees they noticed that men are generally more eager to step forward to operate and thus be visible and perceived as capable trainees whilst women tend to be more cautious and thus be viewed as slower learners, suggesting that female trainees need more "encouragement and positive reinforcement" (SG4, Consultant, UK).

> I think there is a difference in how women learn; I think there is a difference in our confidence. And initially that could be seen as that we're slower to learn but it's not that […] men might watch an operation a couple of times and have a go themselves whereas a woman would never do that, they would want to do it many more times before feeling confident to do it. But it could sometimes seem you're a slow learner but it's just that women tend to take fewer risks, in my opinion. (SG8, Consultant, UK)

Senior female mentor of one of the informants shared the same observation, advising her to adopt this behaviour that she perceived as masculine – a piece of advice that the interviewed surgeon found valuable as she noticed that she indeed tended to put herself forward less than her male peers. Another woman commented that this personality trait – being "gung-ho" – was something that made her experience during training match the experiences of her male counterparts. This finding goes in line with previous research that discovers that women are more prone to "imposter syndrome" (Nomura et al., 2010) and

generally less inclined to take risks and self-promote, risky behaviour and self-promotion being regarded as particularly masculine traits that are to be criticised if a woman adopts them (Valian, 1999, Meyerson et al., 2017).

Besides that, some informants shared that the male trainees are being treated somewhat differently than female trainees, this observation in different narratives varying from just noting the difference to actually reporting situations where a woman felt that she was systematically excluded by a male trainer who preferred to teach her male counterparts. That exclusion put her in a situation where she had to work harder than her male peers to achieve the same level of respect and recognition, the process that is often said to be a consequence of tokenism and is described extensively in the literature about women in non-traditional occupations (e.g. Kanter 1977, Colletti et al., 2000).

> …all male Consultants who tend to dismiss me more than male medical students … they kind of subtly act like your male peers are going to be better than you […] they're being a bit sexist when they prefer to teach my counterpart, you know. (SG7, 3rd-year medical student, UK)

Besides, that informant highlighted that her female peers shared similar stories with her but not all of them recognised such attitude of trainers as sexism. Although she did think that such consultant's behaviour was discriminatory, she did not feel she could do anything about it as she felt that she might be called "oversensitive" and possibly might be mocked if she decided to try to get support with regard to the situation – a problem many women face when trying to report harassment or discrimination (Liang et al., 2019). With surgery being a profession where such masculine traits as toughness and ability to "pull it through no matter what" are highly valued, receiving a reputation of an "oversensitive" woman can lead to much more severe consequences (e.g. exclusion, limited promotion opportunities) than in other professions that are not associated with these traits.

Another woman shared a story where she faced a similar situation where she was dismissed by her superior when she reported that her male colleague who was bullying her was also harming patients. Although people around her knew that it was true, the situation was allowed to continue, eventually forcing the informant to leave the hospital and even the region. Even though this woman did not face any problems finding a new job, her experience of being put in a situation where she had to change the region where she lived and worked supports the statement that reporting a problem might be a dangerous strategy for a woman. She also noted that she knew another trainee who found herself in a similar situation.

> I could sort of cope with the bullying but the problem was that he harmed patients, and so I had to report him to my other boss, and then I was told by the medical director that clearly the problem was that I had a personality clash with this person and you have to personalise less in order to be a cutting-edge surgeon. So, this has been allowed to go on for the last 10 years, only recently being addressed… (SG4, Consultant, UK)

The obvious clash between the cultural logics of the surgical profession and the stereotypes and expectations about women also demonstrate the mechanisms through which gender functions as a structure. Besides, internalised gendered selves (being less self-promoting, less "gung-ho") of women surgeons come into collision with what is expected from successful trainees and they find themselves choosing between complying to the logics of the profession or gender expectations.

"People were a nonsense if they were pregnant"

One of the most gender-sensitive areas within surgery that almost all of the informants named is maternity leave. Clearly, the experiences of men and women in this area are different not only in a physiological but professional way as well. As surgery is traditionally a male-dominated field, the system, as well as the people within it, have difficulty adapting and accommodating women and the fact that they might need a maternity leave.

> I think some of the challenges come up when some of my colleagues who've taken time out to have children, that's where people start to have problems because that's something that the Consultants are less used to dealing with, so they don't really know how to manage it. (SG3, ST7, UK)
>
> …people were a nonsense if they were pregnant… (SG5, Post-FT2, UK)

The biggest concern comes during traineeship as trainees change jobs once or twice a year and leaving in the middle of rotation can inconvenience the whole department. Thus, in some cases, consultants who supervise their work might not have an opportunity to take in trainees who are planning to have maternity leave as there will be no one to take their place. That narrows female trainees' choice of positions where they can do their training if they are planning pregnancy during this period of time. Another issue that seems to be more discussed in the literature, is that pregnant trainees are often frowned upon and are supported neither by their peers nor by superiors due to schedule inconveniences and additional workloads that their maternity leaves cause (Turner et al., 2012), however, there is no support to that in narratives of my informants.

> …they have to definitely choose a job where it won't make a big difference for their consultant if they upset anybody that they're leaving, you know, half-way through rotation and they have nobody to efficiently replace them. (SG6, Consultant, Ireland)

Concerns regarding the maternity leaves seem to be less of an issue for consultants who have already secured their position and their absence is perceived as a necessary short time off rather than a disturbance in the order of things. For these reasons, trainees used to postpone parenthood till getting

permanent positions, however, it seems to be more common now not to do so, which is supported by evidence from some quantitative research as well (Turner et al., 2012).

> You know, I think because you are appointed as a permanent staff member it feels a little easier. […] because you're a permanent staff member and I'm going to be probably working in the same job for the next 30-35 years, so it's less… you know, lots of that's "she's taking 6 months off, that's fine". (SG6, Consultant, Ireland)

Another informant shared her experiences of being a part-time trainee which is another issue connected to maternity and which was uncommon twenty years ago. She reflected that it was difficult back then because in the beginning her superiors had little understanding of what part-time positions in surgery implied. However, according to her observation, now it has become increasingly common as more experience and understanding has been accumulated in the system. However, research demonstrates that there are still not enough less than full-time opportunities in surgery (Bellini et al., 2019).

> I think the world has changed completely because I now have male trainees asking to be part-time or to take parental leave. So that was *really* rare back in my day. (SG8, Consultant, UK)

Although one consultant did mention male trainees wanting to change their work life because of parenthood, another one pointed out that there were "remarkable differences between two scenarios": between male and female trainee having a child. Besides the obvious fact that a woman would have to take a leave to give birth and recover, she noted that the attention that would be given to a male trainee's new parenthood would be significantly less than to the female trainee's one.

> … for a male trainee … things change of course, it's probably acknowledged less or it's about to be less life-changing, it wouldn't be discussed, you know, as frequently as maybe it should be. (SG6, Consultant, Ireland)

In the eyes of the informants, the communication around their motherhood seemed to be an important issue that often did not work the way that would be comfortable for them. Both complete disregard of the fact and humorous comments put them in distress and discouraged them, which indicates that women are still new elements in the system and that their presence does require certain adjustments not only in terms of labour conditions but also in terms of communication techniques that should be used. This finding seems to be of particular importance as, to the author's knowledge, it is not well documented in the existing literature.

> I had a 6-month-old baby at home and I had a male trainer at that time, and he never once asked me, you know was it girl or a boy that I had or, you know, how were there at home or anything. (SG6, Consultant, Ireland)

> …when I came to the end my rotation, he turned around and said to me "oh, I thought you wouldn't turn up half the time" and I'd just come back after my maternity leave and I was quite taken aback by that comment. (SG1, Consultant, Ireland)

The problems that women surgeons face due to their motherhood illustrate how gender is built in in the institutional rules of the profession: the system imagines its workers to be men who have wives to take care of their children thus women face difficulties when they enter it. At the same time, their presence changes the system as well, as now part-time opportunities become more available to surgeons.

How to: Success in the field

Medicine in general and surgery in particular is a highly competitive profession: from entrance to medical school to receiving a consultant position there are selection processes that allow only the best to progress. Such competition has a certain impact on people who try to succeed in the profession; the informants pointed it out on many occasions. For example, one woman shared that during her training there was a perception that in case she succeeded as a surgeon, she would be a competition to her trainers, thus they were not interested in supporting her or giving her opportunities. This seems to be in line with the argument that the dominant group negatively reacts to the increasing number of token members and tries to reinforce the barriers that have kept them out of the profession (e.g. Ott, 1989)

Besides, because competition for surgical positions and trainings is strong, people have to move to places where these positions are offered which means that they have to move away from their homes, families, or partners. This particularly can be a barrier for women who usually have more such family commitments as childcare or taking care of elder members (Grandis et al., 2004). One informant also said that it is often believed that a woman will be the one who follows the man and thus she might have more pressure to not pursue her career goals.

> And so for her that's a big concern because surgical training is more competitive than lots of trainings, and so we have to travel where the job is and so I think she's concerned that if she needs to be in one place for her job and he needs to be somewhere else which one of them is the priority, what way would they go. And I think that sometimes the tendency for it to be that it's expected that the woman would be the person who goes where the man's job is. So that can, that's probably something that I think is weighing on people's minds. (SG2, Post-FT2, UK)

Another issue that rises with the severe competition is the emotional strain that it causes. One informant described the working atmosphere as "aggressive" and "emotionally demanding", especially for women, as she perceived that because of the male dominance in the field women who want to get in it feel that they

have to prove themselves more than men to achieve the same level of success, a phenomenon that is described as a consequence of high visibility of token women in male-dominated fields (e.g. Kanter 1977, Colletti et al., 2000).

> I don't think as a male you need to be that forceful or dominant to get to where they are, they kind of just, you know, fall into it, whereas the women seem to have to work very hard, and so that means that they might be a bit more aggressive or competitive. (SG7, 3rd-year medical student, UK)

She also observed that women in surgery tend to be more aggressive to other women as they feel insecure attacking their male peers who might be viewed as someone who traditionally "have more rights to be there", and that women would rather compete against more "equal players" – other women. However, this observation contradicts accounts that other informants gave on the topic, remarking that they gladly share opportunities with their fellow female peers and get support and inspiration from different initiatives aimed to help and network women in surgery (one local support group and such initiatives as Women in Surgery and BOTA (British Orthopaedics Trainees Association) were mentioned). The literature on women tokens is quite inconsistent in this regard.

> … you share any opportunities that you have to help somebody else. I maybe do that slightly more with female surgeons maybe just because I have more in common, so I'm probably more likely to chat and find out what their career aspirations are, so I could probably give them more of opportunity if I've got something that I think that could be useful. (SG5, Post-FT2, UK)

According to the informants, in the atmosphere of constant competition, overwork and extreme dedication to the profession become the major factors of success, to the level some women regard it more as a professional culture rather than necessity. Cassel (1991) and Kellogg (2011) support this perception, describing surgery as a profession where people who do not work overtime and choose family over a job are not as respected as those who stay in the hospital all the time.

> … a lot of the trainees because of the way they've been trained they'll sort of feel like they have to stay later or that kind of thing, when actually it would be better to distribute the workload better and have only one of them staying later and the rest of them to go home earlier and things like that. That probably needs to change as well (SG6, Consultant, Ireland)

Besides hard work, informants shared that being keen and pro-active, doing research and excelling academically as well as being supported and encouraged by trainers and educators contributed to their professional success. Interestingly, flexibility was mentioned as an important trait that helped them to overcome difficulties that rose because of them being women in a male-dominated profession.

> … as a surgical trainee or as a trainee doctor in general, I think one of the things you learn very quickly and early on in your career is to become very flexible and adaptable in order to survive and progress and you're kind of willing to accept certain things. […] they have had some prejudices, but I guess you just kind of… what you do as a trainee, you find a way to work around this. (SG1, Consultant, Ireland)

Recruitment process: "You're making impression just by being female"

According to the informants' narratives, recruitment processes are moments in their careers where the system is really tuned in such a way that their gender does not matter. Recruitment for surgical training schemes happens once a year on a national level through a centralised system and all applicants go through the same interview panels where their portfolios and clinical, managerial, and other relevant skills are scored.

> … now it's completely anonymous, completely objective, centralized, national selection. (SG3, ST7, UK)

All the informants who went through this process characterised it as objective, pointing out that the system did not allow any questions that could be somehow interpreted as gender-related, some of the informants even noting that such questions are illegal. When comparing the current system with what it was before when people just had individual interviews for particular jobs, they remarked notable improvement in the fairness of the process.

> … when it came to recruitment, it was pretty fair because the system had changed. So, if I were 10 years earlier than that, it would have been different. (SG8, Consultant, UK)

However, women regarded that for these recruitment processes personal impression you make was still relevant. For example, one informant said that there is an unspoken rule that you are expected to be sharply dressed and be "very-very polished and very-very particular". Despite the rule being the same for men and women, she perceived that it was harder on women because the rules of smart dress for women are more blurred whilst "they [men] just wear a suit and that's what they're all wearing, it's quite hard to go wrong" (SG2, Post-FT2, UK). Besides, she shared that she felt that no matter how well she manages to comply with this unspoken rule, "there is a concern that you're making impression just by being female", which does not necessarily mean that it puts her in a disadvantaged position but contributes to the line of argument that gender is an omnipresent category that does not disappear even in pronouncedly gender-neutral settings (West & Zimmerman, 1987).

2.2.2. Relationship with colleagues, superiors, patients and "outsiders"

In this section I will analyse a more personal aspect of the female surgeons' careers – their relationship with people who they work with, who supervise their training, who they provide service to, and who are not in any way connected to

the medical field. Here informants were asked to describe their relationship with these groups of people, attitudes that they encounter, group dynamics they find remarkable and impressions they believe they make by being women in a non-traditional profession.

Relationship with colleagues and superiors

When talking about relationships with colleagues it is important to differentiate the relationship between male and female colleagues as in most cases informants register that they are different. This difference does not necessarily mean that there are some negative attitudes coming from men. One woman remarked that men talk about things that she finds "fairly superficial" like weather or sports whilst women discuss more "intimate topics". Another informant noted that "the quality of the conversations will be very different with a female trainer compared to a male trainer" (SG6, Consultant, Ireland), especially when it comes to speaking about family matters. Although informants did not particularly attribute this difference to gender or perceived the difference as negative, it is possible to suggest that it is a part of a contrast construction which happens when the dominant group tries to differentiate itself from the token one.

This divide grows stronger if male colleagues are older – then relationships become more formal, and sometimes things that women would interpret as inappropriate might be said. Female surgeons explained such behaviour by the fact that older generation of surgeons was brought up in a different environment and some of them had not yet adapted to the changes that had happened in social norms regarding gender relations and equality.

> … certain percentage of them don't even realise that they are behaving in a misogynistic manner, they don't even realise that they are saying inappropriate things, they are just not of that era, and nobody has ever pulled them up on that. […] I think they [younger surgeons] are just more sensitive to us, to be honest, because, you know, the whole media aspect of things, the whole hashtag #MeToo (SG1, Consultant, Ireland)

However, one informant attributed inappropriate behaviours not only to the generational factor but also to the nationality background, saying that the male surgeons coming from "slightly more conservative cultures like India or potentially China or even Polish or Eastern European cultures" (SG7, 3rd-year medical student, UK) are more likely to express sexist views due to lack of gender equality discourse in these cultures.

Besides, female surgeons noted that the increased presence of women in the profession has improved understanding of what is and what is not appropriate behaviour coming from men towards women in a professional setting. It demonstrates that gender is indeed a structure as it functions and models our behaviours without our notice of it and only becomes salient when things start to change: it does not seem that the male surgeons intended to behave inappropriately but they did so because that was how the system (i.e. macho

culture of the surgical field) taught them to and stopped only when women became less rare in the profession and old behaviours were no longer accepted by them.

> I've noticed in my region because we have a high volume of women, my male colleagues are used to having women around, so I don't feel that our gender is as relevant […] And when someone is used to being around a large group of boys and then they have a woman around, then they get a bit confused, I think. They don't always act that appropriately… (SG3, ST7, UK)

However, some informants shared that some sexist and "old-school boys club" culture that is traditional to the profession still persists, although in a less open way than it used to. Mostly it manifests itself through sexist jokes, patronising and questioning of the seriousness of a woman's intention to become a surgeon. Sometimes informants felt it on a more subtle level – through gestures, physical contact and exclusion from activities outside of work, which is common for situations of tokenism.

> …you know, back slapping, hand shaking that, unfortunately, as a woman, you are often not part of. (SG1, Consultant, Ireland)

> They have their own group that they go out and drink, where the girls aren't invited to, every week. (SG4, Consultant, UK)

Interestingly, one informant commented that she might not feel the division in the team not because it is not there, but rather because she personally is used to teamwork with men and shares some interests with them (e.g. sports) while other women might not have the same experiences and personality. This reflection clearly points out to the negotiation around femininity that female surgeons are bound to have as they are occupied in a male-dominated profession, a discussion that according to Hill et al. (2015) is rarely resolved in favour of femininity.

According to the informant's stories, relationship with female colleagues often depends on the position of these colleagues in the hospital. Whilst there are almost no accounts of negative experiences with other female surgeons, several women noted that it is female nurses and midwives who express misogynistic attitudes.

> So old nurses tend not to be very nice, I think sometimes theatre nurses can be a bit difficult with female trainees. (SG8, Consultant, UK)

One surgeon explained such behaviour by the different communication style that nurses use with male surgeons: "they deal with doctors by flirtation and behave very differently with the male doctors compared to the female doctors, and they can't do that with the female doctors" (SG4, Consultant, UK). Continuing this line of reasoning, it seems logical to add that nurses might not see enough authority in female surgeons in comparison to their male counterparts (Yoder et al., 1998) or experience frustration when taking orders from women. For the latter reason one of the informants finds support in her practice:

> …female consultants are much more likely to get complaints from female trainees than their male colleagues from the male trainees. And I think a lot of that is about having a problem taking negative feedback from a woman, that they would accept more happily from a man. (SG4, Consultant, UK)

Relationship with patients

When informants were asked to describe how they build relationships with their patients and what the attitude towards them is, all the informants described the same situation where patients do not realise that these women are the doctors and the surgeons. Quite often female surgeons are being mistaken for nurses or secretaries and sometimes women have to put special effort to make their position clear to the patients. This phenomenon was described by Kanter (1977) as “status levelling”.

> And I’ve also frequently had patients assume that I’m a nurse, a physio, the consultant’s secretary, rather than a surgeon until I specifically tell them. (SG3, ST7, UK)

> …you just have to be a bit more forceful in how you introduce yourself to your patients so that they know who you are. (SG1, Consultant, Ireland)

Informants explain that such confusion happens because patients have an unconscious bias that male medical workers are doctors and female ones are nurses which strongly corresponds to the stereotypes about these professions and about women as someone who provides care rather than professional advice. That is also why sometimes patients in situations when they do not know who the surgeon is are more likely to address men as doctors, a phenomenon called an implicit bias in the existing literature (Davids et al., 2019).

> …if I’m with a trainee that’s quite senior who might be taller than me and a man, they’d assume that he’s the consultant, that’s quite annoying. (SG8, Consultant, UK)

The gender aspect of the stereotype about surgeons and nurses is so strong that when reality contradicts it, people sometimes have difficulties processing and accepting it. These are also the moments when the strength of gender as a social structure becomes apparent as we realise how much assumptions about a person we build solely based on his or her gender and how difficult it is to discard these assumptions.

> I definitely have a lot of people who, when I say I'm one of the surgical doctors, that they immediately read that as nurse, and I have to correct them about four times. And I think it's obviously not … it’s an unconscious bias, people don't realize that they have that stereotype, that actually their surgeon can be …can look like anything, actually. (SG5, Post-FT2, UK)

Informants note that besides gender, their age also plays its role – they believe that patients (especially elderly patients) would be more willing to accept the fact that they are surgeons if they were older, as older age is traditionally perceived as a proxy to experience.

> And some of that is because I'm younger, you know, I think as I get older that will probably become less of an issue. (SG6, Consultant, Ireland)

Women think that their young age is sometimes used as an excuse to question their competence and authority – something that, according to their observation, never happens to their male colleagues. It is clear that in the eyes of patients a strong connection exists between gender and professionalism, the latter being a trait attributed to masculinity and thus not denied to men without a good reason but often questioned in women.

> … you look too young or they really mean "too female". And some… they ask about your experience, whereas they don't for my male colleagues who are as experienced as me. (SG4, Consultant, UK)

> … people kept asking her, you know, "are you sure you're really a doctor" and she would show them her ID badge, and then they would be like "oh did you steal this from someone else" and they would scrutinise it. They kind of say it in a slightly joking way but I've never seen this happen to any of my male colleagues. So, patients do this sexist thing, cause they just look at males and just think "oh, authority". (SG7, 3rd-year medical student, UK)

In extreme cases, perception of women's incompetence and previous negative experience with female doctors are so strong that, as two informants shared, there were cases in their practice when patients refused to be treated by them. However, some surgeons noted that for certain specialities like gynaecology and breast surgery their gender was actually an advantage as it allowed them to build a more trust-based and equal relationship with their patients due to women tending to be less conscious of their bodies around female doctors (Reid, 1998).

> …it's much more sort of equal relationship with them, than my male colleagues would have, he would have more paternalistic relationship. […] I have some really good relationship with a big group of my patients, who're very loyal to me. (SG4, Consultant, UK)

Relationship with "outsiders"

There seems to be another similarity in experiences that all the informants share: when they tell people who are not connected to the medical sphere that they are surgeons, these "outsiders" always express surprise. Some women note that it is usually said with a positive air, with encouragement and support.

> So, they could be surprised that I'm a surgeon cause they don't think that you can be a surgeon if you're a woman and then other people, like women, would be impressed and go "oh, that's great", it just varies. (SG8, Consultant, UK)

However, sometimes it might be a surprise of incomprehension rather than the reaction of being impressed. Informants explain it by the fact that there are not many women in surgery and it is likely that the other person has never met one.

> And lots of people have never met a female surgeon, I'm sure, and quite often people say "oh, wow surgery, that must be really hard" or something like that. I suppose it's a perception, but then I often get a comment being like "oh, there's not many female surgeons, are there?"... (SG5, Post-FT2, UK)

Comments about the perceived challenge of becoming a surgeon and questions about how the woman is planning to combine this work with family life are also something that often follows the first reaction to female surgeons and, in their opinion, never comes up when male surgeons introduce themselves. That might be, again, caused by the perception that a woman is interested in starting a family simply due to the fact that she is a woman. Another informant points out that in different social situations she is being asked whether she is Ms or Mrs, the difference between the two being her marital status, and when she answers that she prefers being addressed as Dr that might be interpreted as being cross which is not how men are perceived in such situations.

> I don't think my male colleagues get Christmas cards addressed to them with their wife's surname and then having lost their professional title which happens all the time to me. (SG4, Consultant, UK)

Although informants said that they generally encounter positive response, most of them said that they prefer not to be open about their profession to new acquaintances. Some explained it by the unwillingness to engage in long explanations about the details of their professional lives, others did not want to be asked for medical advice outside of work. And another reasoning was that they did not want to be "judged based on my job", indicating that there must be a particular opinion or stereotype about surgeons that might influence further communication with people.

> I think it puts up a bit of a barrier sometimes. And if I'm not in a work situation I don't necessarily want… I want to be accepted for being me as an individual, not what my job is. (SG4, Consultant, UK)

Two other informants gave a slightly more detailed insight into the problem. One of them shared that in informal settings she had situations when men would change their attitude towards her because of her profession, instantly starting to see her as "intimidating" and "too clever", which might be explained by the persistence of negative stereotypes about women in male-dominated fields as of women who are not pleasant in interpersonal communication, are not feminine enough and thus cannot be judged by women's standards (Yoder & Schleicher, 1996, Heilman et al., 1995, 2001, Hill et al., 2015). Another surgeon

said that she sometimes faced situations when people would suggest that she might consider them inferior to her, which can be explained by the strength of the "arrogant surgeon" stereotype – a phenomenon that will be analysed below.

2.2.3. Stereotypes about surgery and surgeons

As I have already mentioned in the analysis, stereotypes about surgeons sometimes play an important role in the professional lives of women who decide to work in this field. Because of that it is important to understand what they include in this stereotype, if it has anything to do with gender and gender norms and how they conceptualise themselves within this stereotype and evaluate its influence on their lives.

Surgeon who?

The first thing that women mention when asked to describe the stereotype about surgeons is that surgeons are supposed to be men and that they do not have strong people skills.

- [what stereotypes do you think exist about surgeons?]
- I suppose that you're a man, that you're aggressive and that you have no compassion or empathy, that you do things like throw things around the theatre. (SG1, Consultant, Ireland)

The former one has a particularly strong influence on women's interactions with patients as it has been described above, they do not always realise who their surgeon is or do not trust them as much as they would trust a man. This stereotype also presupposes that a surgeon would have pronouncedly masculine behaviour (e.g. putting yourself forward), character (e.g. decisive, direct), and preferences (e.g. play rugby), as it is well documented by Cassell (1991). In certain specialities, for example in Orthopaedics, this stereotype would be more prominent due to specificities of the job and physical strength – a typically masculine trait – that it is believed to require.

> I think people expect me to be male, I get that a lot, you know, often from … an older generation of patients... (SG4, Consultant, UK)

> Orthopaedics is stereotypically male, rugby player, stupid, it's very historical, yeah. That's kind of stereotypical orthopaedic surgeon… (SG3, ST7, UK)

The latter stereotype – poor people skills – usually results in people questioning women's choice of profession. That can be simply a contradiction that people see between the stereotype they have about surgeons and this particular woman's personality but it is also possible that others perceive such traits as friendliness, empathy, ability to care, and strong communication skills as feminine and thus they (sometimes even unconsciously) ascribe them to all women (Zhuge et al., 2011). And, in their eyes, presumed possession of these

qualities renders a surgery career something unsuitable for women, a contradiction between their gendered expectations about the profession and women's personalities.

> ….and quite often people would be like "aren't you kind of too nice to be a surgeon?" or "you have people skills, so why would you like… you're not…" (SG5, Post-FT2, UK)

Interestingly, these negative traits – unfriendliness and lack of empathy – are viewed as something integral to the profession and part of hegemonic masculinity that prevails in the field, as not only women but also men who do not possess these qualities can be scrutinised as it was also described by Kozar et al. (2004). The difference is that in the case of female surgeons they are more likely to be questioned regardless of their actual personalities while men face this issue only if they demonstrate certain behaviours.

> I do know male colleagues who are particularly nice and friendly who've been told they're too nice and friendly to be surgeons, but I don't think they get the same extent of questioning (SG3, ST7, UK)

Although informants believe that they can bring something that is seen as traditionally female – like "empathy and communication skills and warmth" – and benefit the profession, they also realise that in emergencies they are actually expected to be the stereotype as such stereotypical behaviours are seen as a proxy of professionalism.

> …in an emergency scenario when you have to be a trauma team, that you have to be much louder, much more of a physical presence you would otherwise be. You know, you find yourself trying to fill the stereotype in that scenario rather than being more like you might be in a kind of more normal setting. (SG6, Consultant, Ireland)

Among relatively gender-neutral stereotypes about surgeons that informants name is a dark sense of humour, being an extravert, and enjoying the fast dynamic of the job. These are also the traits with which some of the informants characterise themselves and which might give them a sense of belonging to the group despite the fact that they do not and/or cannot conform to other stereotypes, fitting in with the stereotype being an important factor in creating the sense of belonging (e.g. Moulton et al., 2013).

> I don't fit the stereotype but I do in some ways. So, I'm quite confident, I try to be quite funny, I make a lot of quite dark jokes which is just what I've always been like but it's actually also quite typical of surgeons. (SG2, Post-FT2, UK)

Femininity and surgery

Another stereotype about surgeons the informants believe to exist and which they find at least partially true is that surgeons are extremely devoted to their profession and that it takes so much time and effort that they tend not to have a

life outside the hospital. Both Cassell (1991, 1997) and Kellogg (2011) confirm that it is indeed a widespread stereotype.

> But generally, very dedicated to their work but in an almost unhealthy way, I think we have a stereotype that, you know, surgeons don't really go home and don't really have a home life. And I think that's to an extent is true, and I think in different specialities within surgery that's even more true. (SG2, Post-FT2, UK)

With this stereotype informants explain why there are not so many women in surgery and why there were even fewer women in the past. They suppose that having a family life was and (still is) seen as something traditionally more important to women than building a career and thus few women would choose surgery as this profession is believed to be incompatible with family life.

> …stereotypically people believe that women would want to stay at home more and be with their children, so, that's partly … maybe partly the reason why there weren't many women in surgery previously. (SG7, 3rd-year medical student, UK)

This incompatibility was also used by informants to explain why women quit surgical trainings or do not have families. Although statistics do indeed confirm this stereotype to be true, informants believe that there have been significant improvements in accommodating family life in the lifestyle of surgeons (see discussion in 2.2.1.).

Among other changes in the field that informants observe is that they find that the female surgeons of their generation feel less pressure to fall into the stereotypical image of a surgeon – an abrupt and ruthless individualist. This might mean that power that encapsulates women in certain roles in the male-dominated profession has weakened.

> Maybe we're more comfortable with not having to be as obviously like a big personality and bringing air out of the change room. I think we're more comfortable with working more in teams and, I suppose, being a little bit less of the surgeons stereotype. (SG6, Consultant, Ireland)

Interestingly, this comparison is not made between all "young" and "old" surgeons but between "young" and "old" female surgeons, meaning that there is a particular stereotype about them. Another informant describes it as "they are very fierce rather than they are… I think there is sense, that they are probably less empathetic and they're more ruthless, rather than being anything. Sometimes you get this that they're gonna be bossy or they are gonna be harsh…" (SG2, Post-FT2, UK). Although stereotypical male surgeons were also sometimes described in these terms, it is important to point out that in principle this description characterises surgeons as authoritative, direct and decisive – traits that are at odds with the very idea of femininity (Valian, 1999). Because of that, such description has a more negative connotation when applied to women than to men as it not only defines them in an unfavourable light but also denies them their femininity, making them "less of a woman" in the eyes of others (Valian, 1999).

Other informants confirm that theory: they share that some of their behaviours or attitudes are sometimes characterised as negative while the same actions coming from men are perceived as normal or even positive. Analysis by Bickel (2011) shares this point of view, outlining the importance of gender in whether we perceive behaviours as confident or bossy.

> And I think there is a big difference in perception between how they… you know, behaviour if I was male would be seen as being just decisive and… whereas if I do it, I think it is sometimes considered as being more negative. (SG4, Consultant, UK)

> …you get stressed and you raise your voice, for example, or do something, you will be seen as having a tantrum whereas a man will be seen as being decisive … you know, it's that they treat you in a different way, even though your behaviour is the same as a man's. (SG8, Consultant, UK)

2.2.4. Conclusion

Having analysed interviews with eight female surgeons it is possible to conclude on the following key findings. Women in male-dominated spheres (in this case – surgeons) face difficulties that arise from their token position and the stereotype about their profession as of a job for men and as a profession that is not particularly friendly to and suitable for women. As a result, they sometimes experience lack of support and lack of positive and inspirational female role models. Strong competition and male dominance in the field force them to put more effort than men to achieve the same results. Women are more often questioned about their professional choice and their skills; there are still cases of bullying, discrimination, and sexism. Among the most common problems is communication with patients as they sometimes do not accept that a woman will be operating, do not see women as an authority, and do not trust them, as well as problems concerning maternity leave and childcare and their (in)compatibility with surgical career.

However, there are also significant improvements in the system that attract more and more women into the profession, challenging the masculine stereotype about surgery and making gender a less important factor in professional life.

2.3. Men in female-dominated spheres: Nursing

As well as in the analysis of interviews with women, three key topics will be discussed in the analysis of interviews with men. First of all, I will look into what influence gender has on their experiences from education and work in the field. Second, I will investigate how it manifests itself in their relationship with colleagues, patients, "outsiders", and others. And finally, I will try to relate the stereotype that exists with regard to nursing, nurses and men in this profession with people's experiences in this field.

2.3.1. Education and work experience

In contrast to experiences of surgeons, in nursing people have a clearer division between educational- and work-related experiences as educational programs that allow people to get registered as nurses and practice are significantly shorter than surgical trainings. In order to qualify as a nurse and receive registration a three-year (UK) or four-year (Ireland) degree is required, however, one can choose to continue education and do Master studies and various post-graduate courses that allow advancing in the career, promotion, and specialisation in certain areas.

Thus, several topics regarding job and education will be analysed. First, I will look into factors that influenced the professional choice of male nurses, and then I will outline some important aspects of their educational and work experiences. Special attention will be given to such processes as recruitment and promotion.

Decision to become a nurse: From coincidence to pro-active choice

When male nurses were asked about their professional choices, significant diversity of answers was received. The first important specificity that calls attention was that many of the informants had nursing as their second career and initially did not plan to enter this sphere. Unlike female surgeons, whose choices I would rather characterise as pro-active, some of the male nurses acknowledged that their professional choices were quite accidental (though nobody said that they regretted it). In several narratives the decision to become a nurse was also the result of trying to avoid unemployment and difficulties in finding a job in the professional sphere in which men had specialised before. Such findings go in line with the typology proposed by Williams and Villemez (1993) and Simpson (2005) who named this group of men “finders” (those who happened to be in nursing by chance) and “settlers” (those who came into the profession after experience in more masculine fields).

> I used to work in maintenance in the hospital for a few years but it was a temporary contract and they kept on laying me off. […] And so, I decided then to become a like a porter or an orderly within the mental health services. […] and then there was an opportunity for me to… it was a union agreed opportunity for people who had patient contact to actually go on and do studying fully sponsored by the Health Trust. […] So, it was real accidental kind of thing. More financial decision than anything else. (NS1, CNM 3, Ireland)

Interestingly, many informants – both who had nursing as the first career choice and who switched to it after doing something else – mentioned that they had several female family members who were nurses or midwives. Firstly, it means that they might have given them a better understanding of what this job includes and secondly, they might have been more exposed to the idea of nursing as a career than other men who did not have a family history with this profession,

which, although subtly, could have influenced their career choices. Thus, it is possible to say, that these family members were, in a way, first professional role models for informants who inclined them to enter nursing.

> I mainly got the influence of becoming a nurse because my sister is also a nurse, the eldest sister in the family, so I decided to become a nurse, I think, when I was on my third year in secondary school. I wanted to become a nurse already at that stage. (NS2, CNM 2, Ireland)

> My mom was a nurse, my auntie was a nurse and my sister's a physiotherapist so I applied for the fire service and nursing at the same time, and I didn't get on as a fireman but it did as a nurse. (NS4, Matron, UK)

However, for some of the informants, the choice of nursing as a career was based on the appeal of the profession itself and general inclination to develop in the medical sphere.

> I've always been interested in medical stuff, like I've always wanted to be a medic, not a doctor, paramedic, something like that. (NS5, NQ Nurse, UK)

Quite inconsistent answers were received when informants were asked whether they had doubts about choosing a female-dominated professional sphere. On the one hand, most men said that it was not a big concern for them; they did not think it mattered a lot, and even that they did not know it was female-dominated.

> Well, I wasn't aware that it's very female-dominated, as you've mentioned. In the UK at the moment, I think the statistics is 9% of the nursing field is male, just 9%. But it didn't put me off, it didn't discourage me from becoming a nurse. (NS3, NQ Nurse, UK)

On the other hand, two informants pointed out that they had an image of nursing as a career for women that was strongly supported by their peers and educators in school. This observation is widely discussed in the existing literature as one of the factors that deter men from this profession (Roth JE & Coleman CL, 2008, McLaughlin et al., 2010). Men shared that they felt that in their time in school boys were streamed towards "male" professions such as "doctors or fireman or police or factory working or mining" (NS4, Matron, UK) and that the idea of going into some female-dominated sphere like nursing would be mocked and laughed at by teachers and classmates. Thus, they felt a significant threat to their masculine identity and feared isolation and exclusion.

> … we could quite clearly remember being jiggled very much towards male-dominated jobs and all the girls being driven very clearly towards female-dominated jobs, and not a single thought of mixture, then there was one particular boy in our school that wanted to be a hairdresser and the teacher ridiculed him for wanting to be a hairdresser. (NS4, Matron, UK)

One of these informants indeed abandoned the idea of becoming a nurse after school because of that and came into the profession sometime later. That serves as a powerful example of how gender structure restricts people's choices not through legal mechanisms but through cultural beliefs and expectations and how actor's agencies disregard these constraints nevertheless.

> When I was in high school, I was thinking about doing this but that's what put me off, that it was female-dominated and, you know, my friends were kind of making fun of me and things like that about that. (NS7, CNM 2, Ireland)

However, it is important to point out that in these cases informants described situations that occurred more than twenty years ago, and considering that younger male nurses did not share similar stories, it is possible to suggest that the situation has changed to a more neutral attitude towards boys choosing "female" professions.

Being a man in nursing education

There are two most remarkable specificities that informants highlighted in their educational experiences. The first one is the proportion of men and women in their cohorts – they shared that is was not just that the majority of students were female; the number of men was almost never higher than ten per cent of the group which put them in positions of tokens.

> At the beginning when it was 300 of us, there was about 20 male students, but now I'm one of three those who graduated. (NS3, NQ Nurse, UK)

> …so overall there were about 12 guys in the class, about 10% of the class or more were guys. (NS6, ANP, Ireland)

Besides that, many of the informants were mature students, which meant that they were significantly older than the majority of their groupmates. Regarding that, some of them had concerns about whether they would succeed in their studies as they had not been in formal education for a long period of time. One nurse said that when he had an interview to get admitted to the nursing course, the recruiter even tried to persuade him not to apply because of that. Besides, men shared that as mature students, they were somewhat positioned differently towards their younger peers. One man shared that it meant playing "almost a fatherly role" for them, leading the group, while other nurse said that in his case, he, along with other mature students, were different to the majority because of different interests and goals. These are two interesting examples of how being tokens in terms of gender intersects with such characteristic as age. In the first case, it led to role encapsulation in the position of a "father", observed also in other studies of men in female-dominated professions (Simpson, 2004). In the second case, the informant adopted a strategy of barrier heightening to differentiate himself and his friends (although not all of them were men) from the dominant group (in this case, younger students).

> … we were a bit older, so we weren't really into the whole party college life, we were more focused as older mature students gone into studying and getting on with things. (NS6, ANP, Ireland)

Combined together, these two observations estranged male nurses in the beginning, nevertheless, in general, they described their experiences as positive and good, one informant particularly highlighting the importance of the connections and friendships that he acquired during his studies.

> I was sitting at the back on my first day, and I looked down, of course, it was just like a wave of ponytails and young women. And I thought "oh my god, what am I doing here". […] Sort of there were girls down there and they would be of the same age as my daughters are now and yeah, it was a bit weird. (NS1, CNM3, Ireland)

> …the positive experience was that the connections I've made at the University, that would have been sort of… that became life-long things now people. (NS1, CNM3, Ireland)

In contrast to female surgeons, it seems that role models played a less significant role in professional becoming of male nurses, thus limited support is found for Rajacich et al.'s (2013) argument that male nurse students lack role models and representation. When asked about them, only two informants mentioned that inspirational and supportive nursing professionals – both men and women – were important to their career development. One informant shared that he found advice and help of his fellow students moulding to his career and only one man said that he felt a lack of role models during his education.

- [did you feel that you lack the role model?]
- Yeah, I'd say so, yeah. Just wasn't one for me, so in a definite way …
- [Did you feel that you lack a male role model or just in general any?]
- Just any role model, I'd say. (NS5, NQ Nurse, UK)

When asked whether they felt any difference in how they were treated during their education, almost all of the male nurses answered that they did not experience different treatment in university; however, there could be differences when going into practice on the wards. One man said that they were warned against being used as a crude force, lifting heavy patients and doing all the physically demanding work just because they were men, meaning that their educators considered such practices as unfair and even discriminatory.

On the other hand, the same nurse shared that he felt that as a man he was treated with less sternness than his female peers. According to his explanation, that was the result of a shortage of male workforce in nursing, as supervisors wanted to see them in the profession and did not want to deter them by being too strict. Thus, no support was found for problems described in O'Lynn's (2004) study in which he argued that male nurse students experience negatively differential treatment. The informant himself ascribed such attitude to a "side-effect" of mutual scrutiny that women tend to bring on each other and which was

not placed on him because of his gender. Interestingly, that man shared an opinion that such tough environments were distinctive to female teams, especially in nursing, this opinion being a manifestation of a stereotype about women in general and the group dynamics that make them look less professional in particular.

> I think I used to get it pretty easier compared to the female nurses. I think the hospitals in the healthcare they just like to see male nurses and they like to see men coming, so I think I probably got easier time whereas… Women can be tough on each other, especially nurses […] in Ireland they can be very tough and down on each other... (NS7, CNM2, Ireland)

Promotion of men in nursing: Glass escalator or objective factors?

Another specificity that many of the informants outlined was a proportionally greater presence of men in managerial positions than on such base levels as, for example, staff nurse. Although men said that most of their superiors were women, they suggested that it might be the case that the approximate proportion – that men constitute 10% of the nursing workforce – is tilted towards men on higher positions, especially closer to the top of the hierarchy.

> Well, in management all right, there does seem to be [more than 10%]. It's still much more female-dominated but it does seem that they're… the percentage-wise is probably a bit higher, I'd think. (NS6, ANP, Ireland)

> I think in psychiatry, in my particular area in Ireland it's still… it's male-dominated, senior management is male-dominated… (NS1, CNM3, Ireland)

They also shared that in some cases there was a perception that as men they were going to get promoted faster than women, which together with the previous observation indirectly supports Williams's (1992) concept of the "glass escalator".

> There is still a little perception in some areas in nursing that males get promoted quicker. (NS4, Matron, UK)

However, the informants themselves explained the phenomenon of disproportionate representation of men in nursing in objective terms, finding the reason in how the system functioned and still functions rather than in their higher social status as men and privileges that come with it. They shared that women tend to have more breaks in their careers due to maternity leaves and further childcare responsibilities, whilst men at the same time do not have them and thus can take rising opportunities of promotion. That was especially prominent before the maternity leave legislation was passed as women did not just leave for a short period of time but often left nursing forever or returned in decades when higher managerial roles had already been taken by men. The

improvement of legislation seemed to increase the number of women in the middle management, but not enough time has passed to see the change on the senior levels. This explanation sheds light on how gender used to be and still is strongly embedded in the logics of the career ladder in nursing.

> …women get pregnant and then they disappear for a bit and then come back, and on the time to go on maternity leave, a promotion already comes up and a male nurse can apply for it. (NS5, NQ Nurse, UK)

> All that has obviously changed now with European legislation and maternity leave and parental leave and all that kind of thing. And so, there is a lot more women in middle management than there would have been years ago, but there is none that actually has been able to … these boys haven't retired yet, so… until they retire there is no vacancies. (NS1, CNM3, Ireland)

Moreover, informants noted that although men also have families and children, taking care of them is more often considered to be a woman's responsibility due to their "traditional caregiver role within the family", which falls in line with the previous discussion about perceived priorities in women's lives (see 2.2.3.). Among the consequences of such prioritising is lack of time and energy that the informants mentioned as one of the reasons why female nurses do not aspire to managerial positions as much as men.

> I think it's more that they don't have the energy, a lot of it, because there are so many demands on them… (NS6, ANP, Ireland)

> I guess it's just harder for female […]. The regular nursing roles with the different shifts and having the days off kind of seems to suit them better, whereas I think men, we don't have… we have children but, you know, we don't have the issues with childcare that females have, and we don't have maternity leave and things like that, so I think that probably does make it easier for male nurses to move up to the management role. I know it's unfair on females but it's probably the reality. (NS7, CNM2, Ireland)

Discussing the issue, one of the informants suggested that possibly it was not the case that men were more represented in managerial roles but rather that they were noticed more due to the fact that in general there are so few of them in the profession – an explanation that directly illustrates the visibility effect of being tokens.

> So, I think that just because there's less of us, you're more visible when you're being promoted and I think it's that that's the difference rather than the actual favouritism. (NS4, Matron, UK)

Although the reasons for an increased presence of men in nursing management is a topic of debate, it seems that direct favouritism is actually not a reason for that as for all the positions informants had to apply and go through a competitive recruitment process that included anonymisation of their applications and sometimes even nationwide recruitment campaigns. Sometimes they were

supported by their current managers, but in most cases it was their personal decisions. As one of the informants remarked, the days when "managers would have promoted or pushed people that they liked" were in the past.

> Where I work, every single promotion within this hospital, all promotion is based on… you have to apply for the job and be short-listed and then interviewed, yeah, there is no straightforward just slotting into the next level above, that doesn't happen. (NS4, Matron, UK)

Recruitment process: Surprises and advantages

Talking about recruitment, informants perceive this process being rather objective as the procedure is structured as a panel interview where candidates score points for certain skills and competences. In Ireland, vacancies are advertised nationally and the panels are run on the national level. In the UK, the short-list of candidates is anonymised and interviewers cannot have their minds pre-set for the people coming.

> … it stops any nepotism or any local interference in people progressing as managers […] all these positions are nationally advertised in paper. […] people sort of score points when they're interviewed, and when you're interviewed these points will put you in positions from number one to number, say 120 for the whole country and that is called the panel. And panel is formed, and as the places come up around the country, you're offered these positions as per the place on your panel, it is very-very fair and equitable. And definitely not gender based. (NS1, CNM3, Ireland)

Besides, only one informant shared that the commission that was interviewing him gave their attention to the fact that he is a man and even then, it was just a reaction of surprise rather than negativity. In fact, that nurse even thought that his gender was an advantage because, as was already mentioned, there are not enough male nurses, and it is often that managers would like to have them around as it allows more equal service to patients if they prefer to be treated by a person of a certain gender. Generally, the perception of being a man in a female-dominated field as an advantage goes in line with previous findings (e.g. Floge & Merrill, 1986, Cottingham et al., 2018)

> If anything, it probably did me… it gives him more of an advantage, unfortunately, because not many wards have male staff, and having male staff gives you the opportunity if your patients have both genders, just in case they wanted a man instead of a woman. That puts in my favour. (NS3, NQ Nurse, UK)

Implicitly, an informant who had experience in employing nursing staff, confirmed this finding, saying that they are "trying actively recruit males into nursing" (NS4, Matron, UK).

Moreover, a psychiatric nurse shared that in his field there is a quota for male employees in hospitals where there are no security teams. He explained that men are considered to be able to deal with potentially violent and aggressive patients better than female nurses, a strongly masculine stereotype about men and their physical strength being clearly visible in this situation (Pullen & Simpson, 2009).

> … in my county Mayo, it's still just all psychiatric nurses which means that there has to be a quota of male staff on duty. Basically because of the perceived risk. (NS1, CNM3, Ireland)

Changing jobs: Irish context

Another interesting experience that Irish nurses shared was connected to the difficulties in the horizontal career movement. They pointed out that their management could place them in positions that they did not choose and did not want. One man commented that even though he received additional education in one sphere, he was not placed to work there as his superiors needed him elsewhere. In his opinion, such approach was the result of an "old-fashioned management structure".

> Often you can talk to management if you'd like to change your position and work in a different area, but it's a very big… But managers or senior managers are very old fashioned in Mayo. They are not really, they don't seem to encourage you to… they don't place you where your education… (NS1, CNM3, Ireland)

Additional problems appeared during the economic recession in Ireland when hospitals faced staffing issues and working environments started to get tougher. An informant shared that he considers himself lucky as his request to transfer within the hospital was accepted when working conditions became unbearable to him.

> …you know, literally, there are some people up in the ward who have put a request in to move two years ago and they're still there. (NS6, ANP, Ireland)

As one of the ways to have more chances to be granted a transfer, this informant mentioned improving his qualification through additional education, in his case, receiving a master's degree. When describing their career paths, other men also explained that they went into further education to get promotion and advance in their practice.

> I decided to do my master's because I wanted to obviously advance my career and further advance the knowledge in my field. (NS2, CNM2, Ireland)

Although it is clear from the informants' narratives that problems with horizontal movements are not particularly gender-related, observation of one of the informants is curious. He notes that some women decide to prioritise their family responsibilities over going into higher levels of education and thus, first, they do not improve their chances to get transferred or be eligible for promotions, and second, they become less competitive compared to men who can afford to prioritise education, which might be another mechanism of the "glass escalator".

2.3.2. Relationship with colleagues, superiors, patients, and "outsiders"

Similarly to the interviews with female surgeons, male nurses were also asked about the relationship that surrounds them in their work environments. Thus, in this section, I will analyse how men communicate with their female and male colleagues, what the reaction of patients to them is, what comments people who are not in medicine give to male nurses, and what specifics their interpersonal relationships have.

Relationship with colleagues

When talking about what differentiates male nurses' relationship with colleagues, the first thing that catches the eye is the absence of consistency in the informants' answers. Some men insist that there is no difference in how they communicate with male and female counterparts and how they, in their turn, see them, other men say that this difference is constitutive to their relationship. Opinions that fall in between these two extremes also appear in the recorded narratives.

What most men pointed out is that in whichever way the relationship between colleagues develops, professionalism always remains a priority and, in general, the atmosphere stays amicable. There were no stories shared in which any type of interpersonal conflict would affect the job of the informants. Contrarily, men rather felt that their female colleagues "liked having a male nurse around". That is a somewhat surprising finding as previous research rather highlighted distance between male and female nurses and experiences of exclusion from the dominant group (Floge & Merrill, 1986, Heikes, 1991)

> There is no difference at all, I don't see them as female and a male, I see them as a contributor in a team, part of the team. (NS2, CNM2, Ireland)

> …it's been quite welcoming, I've never had anything, any trouble or anything like that. Attitudes, all the same, the general attitude in every place I've been is that the priority is the patient, comfort of the patient and just getting that patient better, the welfare and the safety of that patient, so all the attitudes are shared. (NS3, NQ Nurse, UK)

There were two reasons which male nurses mentioned as ones potentially capable of creating problems. The first one they attributed to a clash of personalities which, in their opinion, was something normal to any group and something that does not depend on gender.

> I got on with him as much as I got on with… as much or as little as I got on with anybody else. There wasn't… just because we were two guys, didn't really matter. And same with the girls, you know, it's like in any group. There are people who got on with each other… (NS6, ANP, Ireland)

> Sometimes working with different people however is… can be different from ward to ward. […] I don't really… some personalities, I think, some people have got quite big personalities and often will clash with other personalities on the wards. Yeah, I think it's more personalities than gender. (NS3, NQ Nurse, UK)

The second reason would be a "clicky" atmosphere that is described to be particular to female-dominated teams of nurses. As was discussed in 2.3.1., in informants' opinion, their female colleagues tended to be more critical of each other which resulted in tensions inside the group. As men were not subject to such attitudes, they seemed not to experience the scrutiny itself but rather noted rough environments as its consequence.

> …women sometimes can make environment a bit clicky […] Sometimes when you work with a bunch of women, they can often be very hostile to each other, they're not particularly nice to each other… (NS3, NQ Nurses, UK)

In contrast to that, male nurses noted that men do not behave in this way and describe their male colleagues as "laid back, calm and relaxed". It seems that as well as female surgeons, female nurses adopt hostile behaviours towards each other due to reasons described in 2.2.1.: because of their gender, men appear to them as figures of authority, whilst fellow women need to prove their right to be where they are (Floge & Merrill, 1986, Colletti et al., 2000).

> …men seem to give each other better support than to be so critical. (NS7, CNM2, Ireland)

> … some [female nurses] I feel giving a little bit more respect [to male nurses]… (NS4, Matron, UK)

One informant also pointed out that the presence of a man changes the situation and dynamics and that the way male nurses communicate with each other is different from how they do it with female colleagues. He explained that he, as well as other male nurses, tends to be more polite and respectful when talking to a woman, whilst with men he uses more humour and feels more relaxed to say whichever things in whichever manner. This situation can be a result of internalised gendered behaviour that instructs men to behave courtly towards

women and in their presence. Although pleasurable per se, such attitudes are clear markers of existing gender structure and inequalities embedded within it. Implicitly the informant himself confirms that:

> …people aren't thinking of it, and actually of the slightly older population, maybe historical stuff that's going, it might be historical views and opinions, you know. (NS4, Matron, UK)

Another reason that men gave as to why their relationships with female colleagues were different from those with male ones was lack of common interests. They noted that women discussed "makeup and fashion" whilst men talked about "rugby or football" – both groups of topics being strongly marked as female and male, respectively. As was already mentioned, emphasis on these differences can be a part of boundary heightening strategies that men might adopt to protect their higher social status which their gender entails. Interestingly, in some cases, not being included in conversations about "women's" things did not influence general inclusion of male nurses in teams, but in other cases it was just another social activity in line of others in which male nurses did not participate – either because they were being excluded or because they did not want to participate.

> Some things that I'm not really included in are certain conversations between females between each other, such as certain like television programs that I've got no interest in whatsoever, certain fashion, you know, […] But other than that, general chit-chat, general events, we do stuff together, we go out for meals and stuff. It's very… very close, I'm not excluded from anything major, just maybe the odd chat now and then which I've got no interest in… (NS3, NQ Nurse, UK)

> You know, they [female nurses] go on nights out and stuff, but I wouldn't… it doesn't bother me, I wouldn't go with them. (NS7, CNM2, Ireland)

One of the informants pointed out that his relationship with female colleagues could be influenced not only by his gender but also by his sexual orientation as he was a gay man. According to his observation, some women were more sympathetic to him, which is a common phenomenon encountered in gay man interactions with heterosexual women as women perceive these men as someone who is more feminine and thus has more in common with them (Grigoriou et al., 2004).

Due to the specificities of the psychiatric field, an informant employed there noted another difference that marked relationships between men and women in nursing. He said that it is expected from a male nurse – both by the colleagues and managers – that he would deal with the situations of potential violence and aggression, and thus, female nurses rely on them to take care of such situations. According to this informant's observation, women tend to pass on these cases to male nurses more often than they could have if they decided to take responsibility and try to deal with the situation themselves. This man shared that fulfilment of this custodial role is even more expected of him by elder members

of nursing staff due to the historical development of the male role in psychiatric nursing. Besides, he pointed out that work in this risky environment binds male nurses together as they have to rely on each other in their every-day work.

> …older nurses still think of you more as of … wouldn't say a prison officer but you would be expected to fulfil a sort of traditional role as a male psychiatric nurse, and that is that you … if anybody was giving trouble rather than trying to deal with it themselves they would often use the option "I'll call the male nurse", you know. (NS1, CNM3, Ireland)

Thus, although some male nurses insisted that there is no difference in communication between them and their female colleagues, others noted that it differs in several aspects – choice of words, topics, and styles. Men differentiated themselves symbolically and rhetorically from women, often creating a positive image of the male group in contrast to that of the female group: "relaxed and laid back" versus "clicky", team spirit versus unwillingness to take responsibility, etc. By highlighting the differences, men were engaging in creating boundaries between themselves and the dominant group. However, it is not clear for what reasons men were "guarding" their identities: whether because their female colleagues – the dominant group – resisted to accept them as Kanter proposed (1977), or because they did not want to be associated with the lower-status gender group and wanted to keep their dominant position in the wider society outside the hospital as suggested by Heikes (1991).

Relationship with patients

Describing their relationship with patients, male nurses outlined two factors (besides gender) that appeared to have some influence on such relationship: age of the patient and perceived sexual orientation of the nurse. In combination, these two factors created situations where elderly service users perceived male nurses as being gay due to a strong stereotype about men in this profession (which will be discussed further). And as homosexuality tends to be less accepted among the older generations (Bernstein, 2004), they might have expressed more negative attitudes towards male nurses than younger patients. However, it seems to be less of an issue now, as one of the informants who is a gay man shared that although he is quite open about his sexual orientation, he has never experienced any problems connected to that.

> When I first started, a lot of the older, older generation would accuse me of being gay, homosexual because I was a nurse. That hasn't happened for many-many years now… (NS4, Matron, UK)

> I've never really had any issue with it at all. Never from any work colleagues or from any patients too […] if someone says maybe like "oh, I see you're married what does your wife do", you know I'll correct them and say "well I'm not married to a woman, my husband whatever works at wherever". So, I've never had any negative reaction to that. (NS6, ANP, Ireland)

Interestingly, that last informant believed that age did not really influence whether a person is going to be acceptant of you as gay or as a male nurse. In his opinion, cultural or religious beliefs tend to be a stronger factor in this case.

When generally describing reactions of other people, male nurses characterised it as a “surprise” or “neutral”. They noted that people used to be less accustomed to seeing men in nursing and thus were more puzzled when they were treated by one. However, now because of the increased number of male nurses, nobody takes notice of that or, at least, they do not verbalise it as openly as in the past.

> It's definitely changed, like when I first started nursing people used to be shocked “oh my God, male nurse” … it's not a big deal anymore. It just seems to be a lot more male nurses now compared to previously, you know. (NS7, CNM2, Ireland)

Besides neutral attitude, male nurses point out that in fact, some patients prefer to be treated by them rather than by women. Informants explain that it is more common among younger men who might be more conscious of their bodies and thus feel uneasiness in front of women. It also might mean that the stigma around homosexuality and/or stereotype that marks male nurses as gay have eased, especially among younger generations. However, informants shared that sometimes women are wary of men attending to their care and prefer to be treated by a woman, probably, first, due to the reasons, discussed in 2.2.2. when women preferred female gynaecologists and breast surgeons, and second, because of, as Evans (2002) suggested, a more sexualised and threatening perception of a man’s touch. Only one informant shared that he had cases where male patients refused his service because he is a man, although he said that it was very rare.

> …my experience of being on the wards that sometimes males are often preferred by some people, say all the young men that are patients, they often prefer a man looking after them, cause certain things could be quite embarrassing for a woman to look at on other young men. Vice versa as well, it's that young women that would prefer women as nurses instead of men… (NS3, NQ Nurse, UK)

> I’m in [urology] nursing now for about 13 years, I think I've only ever had like maybe once or twice where some would say they prefer a female nurse... (NS6, ANP, Ireland)

A psychiatric male nurse shared that he has additional difficulty in building relationships with patients that female nurses do not experience. Due to the fact that in acute admission units male nurses sometimes have to restrain involuntary patients, their relationships are less trustworthy from the very beginning, a factor which can influence the quality of the provided care.

> Although you do talk to the people afterwards to debrief them, to explain to them why they had to be held to have the medication, I do think that that can impinge on the relationships. (NS1, CNM3, Ireland)

Another difference in attitude that male nurses note in comparison to their female colleagues, is that they often get mistaken for doctors or technical staff, the same way as female surgeons are mistaken for nurses or secretaries. The arguments and explanations that were presented in 2.2.2. seem to be true for the case of male nurses as well, as nursing is strongly stereotyped as a profession for women, and the same bias drives patients to address any man in the hospital as a doctor and any woman as a nurse.

> I get confused for a doctor about 5 times a day: “are you the doctor?” – “no, I'm just a man in a nurse uniform that’s all” (NS3, NQ Nurse, UK)

> I presume, that happens most to male nurses, you know, you come to the bedside and everyone… somebody says “are you the doctor?” (NS7, CNM2, Ireland)

What is different in this situation is that whilst in female surgeons patients question their skills and qualification, men are rather questioned about reasons that led them into nursing and how do they find this experience, which seems to be a less discriminatory, derogatory and frustrating question.

> A few would ask inquisitively all sort of “why did you get into nursing at all”, “have you found it different or challenging working with all female colleagues”. (NS6, ANP, Ireland)

Relationship with outsiders

Similarly to female surgeons, male nurses also sometimes encounter surprise when people who are not in medicine discover what their job is. And similarly to female surgeons, this surprise is not coloured with negativity. Informants share that in general, they have received positive reactions from people: some admire and respect them for doing hard socially important work, some support them in their decisions to become nurses, some react very neutrally.

> Often I get people saying it’s great field of work to get into, they admire me for making that decision to become a nurse, they know it’s quite a tough job to do, very-very hard to do, it’s not the best paid in the world, but I don’t think you really go for nursing for the money. It’s admiration really, you get a lot of respect. (NS3, NQ Nurse, UK)

What is remarkable in the answers that informants give is that they often describe attitudes of other people ex adverso to what they would expect as a reaction. For example, they say that they have never been judged for being nurses or have never been told that it is not a proper job for a man, which means that they feel that there could be such attitudes in the society. It is possible that these assumptions are based on attitudes that were common in the past and had originated from the historical development of nursing as a profession for women and stereotypes about men in it (see discussion about stereotypes further). The existing literature on male nurses strongly supports that negative judgements of outsiders are indeed what deters men from the field (Roth JE &

Coleman CL, 2008, McLaughlin et al., 2010) and remains a source of a constant need to guard and shape their masculine identities against the outside-of-hospital world (Pullen and Simpson, 2009).

> I don't think people had the same attitude 20 years, 10 years ago towards male nurses, so I never, thankfully I never experienced any, anything that was judgmental about my job… (NS2, CNM2, Ireland)

In contrast to female surgeons, no one from the interviewed male nurses said that they have ever decided not to share what their profession is with non-medical people. And again, some of them explained it ex adverso, telling that they are not embarrassed by their profession, suggesting that such sentiment is possible in other men or was possible in the past, an assumption proven in the existing literature on male nurses (Pullen and Simpson, 2009).

> If someone asks me, I just tell them I'm a nurse. I just don't feel embarrassed by it at all. (NS5, NQ Nurse, UK)

2.3.3. Stereotypes about nursing and nurses

As it was already demonstrated stereotypes about the profession play an important role in the professional lives of male nurses. In this section I will analyse what this stereotype consists of, what transformation it is going through, and how male nurses negotiate with and challenge hegemonic masculinity.

A nurse: From a woman at the bedside to a care professional

The first interesting observation that can be made relying on informants' descriptions of the stereotype that exists with regard to the nursing profession is that although they do say it is a "women's" job, some of them point out that this stereotype does not exist anymore. Informants who have been in nursing for a longer period of time say that the perception used to be that all nurses are "predominantly female and all sexy" (NS4, Matron, UK). Previous research confirms that it was, indeed the case (Jinks & Bradley, 2004), however, quite a different image of a nurse does also exist and has historical roots in the British culture due to Florence Nightingale's heritage. That image depicts a nurse as a caring, selfless woman who helps all the suffering (Jinks & Bradley, 2004). One of the informants mentioned this stereotype saying that "[nurses are] caring, passionate about what they do. Professional at all times, you can't really turn it off. […] With nursing it constantly carrying around with you, you're looking around just in case anything's happening." (NS3, NQ Nurse, UK)

Although whichever is the stereotype that nurses believe exists about their profession, both include traits that are ascribed to women and femininity. Being sexually desirable as well as providing physical and emotional care are viewed as qualities that women either possess or aspire to possess exclusively by the nature of being women (Beauvoir, 1949/2011). The former leads to the depiction of a female body as of an object of sexual desire, to the prevalence of

importance of physical appearance over professional skills and marginalisation of women's role in professional activities (e.g. Kanter, 1977). The latter rises from the role of caregivers and mothers that are traditionally ascribed to women and lead to the perception that all women are empathic and caring as was discussed in 2.2.3.

However, as it was already mentioned, informants perceive that the stereotype has changed and now there is little that makes nursing look like an exclusively "female" job. One informant gives an interesting opinion on why it has happened. He says that the change of the stereotype is the result of a change that happened to the profession of nursing itself. He compares duties that nurses had ten-twenty years ago to what they are now and concludes that the role has become more autonomous, that responsibilities of nurses have widened, and this change is visible to patients. And as the perception about what nurses do has changed, the image of who a nurse is has changed as well because the role has lost part of its traditional bedside care aspect which is stereotypically performed by a woman and thus is considered to be easy, and evolved into a job that requires special skills and high levels of professionalism – traits that are traditionally ascribed to men. Although it is indeed true that nursing has gone through the process of professionalisation in the past decades, it is also very important to note that such discourse is a clear example of how men construct their masculinities through highlighting more masculine traits of the profession and play down the importance of the feminine ones, a process extensively described in the existing literature (e.g. Lupton, 2000, Cross & Bagilhole, 2002)

> …they all thought nurses are really just for female because they give bath to the patients and that's it. That's a superficial aspect of the career, there's more to it … and particularly nowadays, the career has certainly developed into a much more, kind of, autonomous versus what the role was back in the day 10 years, 20 years ago. (NS2, CNM2, Ireland)

> I think patients and their families and their relatives have certainly seen the improved role, the bigger responsibilities that nurses have on their shoulders. So, I think the gender is not a question anymore nowadays. Whether you're a female nurse or a male nurse, in their heads they are now thinking that nurses are now really, you know, have certainly evolved in that aspect. (NS2, CNM2, Ireland)

Another stereotype that does seem interesting in terms of its gender aspect is the image of a matron. As one informant shared, people in this managerial role in nursing are expected to be women, to be "dragons" and to be someone "to be feared" (NS4, Matron, UK). This informant tells that historically they would be virtually the only female staff in the hospital whose opinion would matter to consultants as medical sphere used to be extremely male-dominated and nurses did not have much authority and power. The gender aspect is interesting in this case as progression in the career and adoption of more administrative functions which are stereotypically "male" tasks, shifts the image from a kind, attentive caregiver to a forceful and strict tyrant. As was already discussed in 2.2.3., adoption of traditionally masculine roles forces women to adopt certain

behaviours in order to be heard and followed, behaviours that are usually in odds with ideas of femininity and thus expose women to a more negative perception and typecasting.

"Nursing is not very macho"

Besides the general stereotype about nursing, the informants were also asked what stereotype exists about male nurses. The answer that almost all the informants gave was that they are believed to be homosexual.

> …normally the assumption is that man is gay, that male nurse is gay. (NS3, NQ Nurse, UK)

> A lot of people would presume that male nurses are gay. (NS7, CNM2, Ireland)

Such perception demonstrates that men who are doing a "women's" job or performing tasks that are traditionally done by women – in this case, care and attending to the sick – are seen as effeminised and far from hegemonic masculinity, as homosexuality in this case stands as a proxy of such characteristics. Although informants share that in their perception most of the male nurses are actually heterosexual, they feel that their masculinity is often under a risk of being questioned. As I described earlier, some of their answers indicated that they expect others to question their professional choices, ask about their sexual orientation or even judge or stigmatise them based on this stereotype.

> …back in the Philippines, when I was still doing my secondary years, I think people can be very judgemental in the society […] people can easily judge you to say, you know, "why are you doing this?", "this is only mainly for nurses… of female gender because, you know, they're taking care of the sick people". (NS2, CNM2, Ireland)

In this context physical appearance becomes an important factor that either reinforces this stereotype or makes it less applicable. Thus, men who lack traits dictated by hegemonic masculinity, such as athletic body build, might be viewed as more feminine, although they might not have been seen as such if they were employed in a more masculine profession. And vice versa, a man who possesses these traits would not even be believed to be a nurse, let alone their masculinity being questioned.

> …often think that I'm a bit more feminine, cause I'm in a feminine… a female-dominated job, so… I'm not a builder, I'm not a big strong man, I'm not one of these grumpy, nasty men, no, I'm quite caring man. (NS3, NQ Nurse, UK)

> I do look more like a bodybuilder than a nurse, yeah. I think it's quite funny actually when people find out who don't know. They don't believe me at first, some people actively don't believe me and still don't believe me. I had to produce my nurse NMC PIN Card to prove it sometimes. (NS4, Matron, UK).

However, even though male nurses' masculinity might go through certain scrutiny, there are ways that they use to re-establish it. First, men are often asked to lift patients or restrain them (in case of psychiatry), which means that they are perceived as stronger members of the team, thus they can exercise their masculinity by performing these tasks and demonstrating physical strength, a typically masculine trait. As Heikes (1992) suggests, conformity to such demands might increase role encapsulation as of a "He-Man" but also is rewarding in terms of identity-building.

> …but the men will take the lead in the physical restraint, basically because of physical size and perceived strength. (NS1, CNM3, Ireland)

Second, men often prefer specialities of nursing where such application of strength is more common, for example, psychiatry or emergency departments (Snyder & Green, 2008). Besides, jobs in these areas are connected with action and adrenaline – things that are considered to be a male sphere of interests.

> Maybe it's the action and the adrenaline and, you know, the emergency situation. It just seems to be a place [emergency department] that just seems to draw male nurses, it's a place that they like to go. (NS7, CNM2, Ireland)

And third, they can challenge hegemonic masculinity, questioning stereotypes and norms about men and what it means to be a man. However, Pullen and Simpson (2009) conceptualise such identity formation as "projects of femininity" and not really as an undoing or challenging of hegemonic masculinity. According to one of the informants, nowadays male nurses face far less stigma as a social norm is changing towards acceptance of a wider range of masculinities.

> I am gay anyways, so I didn't particularly care if people found one way or another. (NS6, ANP, Ireland)

> Some people think that men can't care or are not passionate enough, that's rubbish, complete rubbish, they can, they can still do the job. (NS3, NQ Nurse, UK)

2.3.4. Conclusion

Having analysed interviews with seven male nurses the key findings would be as follows. Experiences of men in female-dominated spheres (in this case – nurses) are influenced by stereotypes about their profession as of a job for women and as of a profession of care only to a certain extent. On the one hand, their masculinity is often under the risk of being scrutinised as they are perceived

to be homosexuals or effeminised, they sometimes are used as brute force to help with physically demanding tasks, and most importantly, they sometimes feel that they do not belong to the team as gender lies as a strong dividing factor between them and female nurses. Besides, the power of the stereotype used to be so strong that in some cases men did not dare to pursue a career in nursing as they feared bullying and isolation because of being perceived as feminine and/or gay, and came into profession much later. On the other hand, men see that sometimes their gender gives them an advantage in building a career, however, it is not completely clear whether it is because their family responsibilities do not interfere with their jobs whereas female nurses assume most of such responsibilities in their families and are bound to have breaks in their careers, or due to the “glass escalator” effect. Moreover, it seems that male nurses do not feel that their gender is an important factor of their professional interactions and communications.

The change in the social norm towards acceptance of a wider range of masculinities as well as changes in the profession itself seem to have weakened the strength of the gender stereotype around nursing and attracted more men to the profession, which, in its turn, also had changed the image of a “typical” nurse.

3. Conclusion

At the beginning of this study I posed the following research question: “What is the role of gender in self-perception of education- and work-related experiences of male and female medical workers occupied in non-traditional professions?” Below, I would like to answer this question by presenting the answer in the light of the integrative paradigm, the key points of which I outlined in the theoretical part of my research. As I mentioned there, “gender as a social structure” theory suggests conceptualising gender through three dimensions: individual level, interactional level, and macro level.

Allow me to begin with the individual level. Being occupied in a non-traditional profession poses a serious challenge for the gendered selves of such workers. Women in surgery often characterise themselves with typically feminine traits: as someone who has strong people and communication skills, who can be empathic and caring. However, the “old boy club” culture and macho image of the profession devalue these traits of female surgeons. They, in their turn, react by either altering their identities towards more masculine or rather androgyne types, or by seeking alternatives within the system: choosing more “female” specialities, participating in women support communities, or sometimes quitting the profession. Paradoxically, some women choose surgery because they see this career as one that fits their personalities in terms of it being dynamic and practical.

Male nurses also experience strain to their masculine identities. From a cultural aspect of it, as a profession of care, nursing requires men to have and demonstrate this trait which is traditionally associated with femininity. Previous research, as well as my findings, show that men have two strategies of reaction to that: either they question the cultural belief that men cannot care, on practice demonstrating that they can and verbally claiming that it does not make them “less of a man”, or they emphasise other, more masculine or neutral aspects of their jobs like high requirements to their professionalism, amount of skills and knowledge they must acquire, dealing with difficult patients, and assisting with physically demanding tasks. On the material level, male nurses’ bodies become subjects of concern or ambiguity as strongly masculine build leads to questioning of their belonging to the nursing profession, however lack of this build puts their masculinity under scrutiny.

Turning to the interactional level of the gender structure, it is possible to say that this is the level on which gender has the biggest influence on people occupied in non-traditional professions. For women surgeons, it is salient both from material and cultural aspects. Although in the United Kingdom technically women are not tokens (they comprise 27% of the workforce whilst token status means being in a less than 15% minority), in the Republic of Ireland they are, and women in both countries feel that they are in a clear minority. Findings demonstrate that in some cases this status created what previous research has found for those who are in a token position – women lack inspirational female role models, they are excluded from informal socialisation, and their visibility pushes them to work harder than their male colleagues for the same career outcomes. Female surgeons also note that when they stop being so underrepresented their situation improves. However, it is possible to suggest

that women's minority status prompts them to unite in support groups and communities that exceed local statuses and become influential enough to initiate systematic changes, as, for example, Women in Surgery initiative within Royal College of Surgeons in the UK and RCSI Association of Women Surgeons in the Republic of Ireland.

In the cultural aspect of the interactional level, women surgeons have to deal with the consequences of other people's expectations about their skills, manners, and behaviours more than often in their professional lives. As one of the strongest stereotypes in the medical field is that a doctor is a man and a nurse is a woman, female surgeons are not perceived, first of all, even to be surgeons, and are not considered to be competent and authoritative enough to provide medical advice and operate. That leads to frequent confusion and misunderstanding in communication with patients, tensions and scrutiny from colleagues, and personal frustration. The expectation about what female surgeons are supposed to be is that they will become mothers, which, in the context of tight schedules and culture of expected overwork, might be viewed as a disruption not only to the personal development but to the whole department.

Male nurses in both the United Kingdom and the Republic of Ireland find themselves in token positions, however, they seem to be less affected by it. Whilst women surgeons do report cases of discrimination and bullying, none of that was found for male nurses. In terms of exclusion-inclusion dynamics, men seem to be in more control of the level of participation in informal socialising with their colleagues: some experience no obstacles to it and some choose not to be involved, highlighting differences between men and women and lack of interest in "women's" conversations and activities. The token status of men in nursing does not seem to have a negative effect on their career development, however, the "glass escalator" effect is also not strongly supported by the findings of this study, as men's advancement to higher positions might also be explained by the logics of nursing as a career that presupposes no long-term breaks in practice and educational advancement which women struggle to have due to family responsibilities and maternity leaves.

From the cultural aspect of the interactional dimension, there are two most prominent expectations that men are supposed to comply with. The first is providing help with physically demanding tasks like lifting heavy patients and dealing with aggression in psychiatric settings. Some men feel frustration due to these expectations, stating that these tasks are not part of the nursing job and even contradict its core as of a profession of care. However, other men seem to consider such expectation normal as they also do perceive themselves as more fit for such tasks than their female colleagues, thus complying and reaffirming their masculine identities. The second interactional expectation that male nurses face is caused by feminine stereotype about the profession. People outside the hospital might perceive male nurses as homosexual or effeminised, and whilst informants say that they did not experience any stigmatisation because of that, they seem to be vigilant of such possibility and are fast to deflate any "suspicions" about their sexual orientation.

On the macro dimension of analysis, gender also has influence in both cultural and material aspects. For women in surgery maternity leave policies and possibilities to work less than full-time are important concerns that impact their reproduction decisions. If making the choice in favour of becoming mothers, they experience problems in communication with superiors and feel lack of support from their side. That is also explainable from the cultural logic of the surgical profession that has been shaped for lifestyles of ambitious and married men for whom career is always a priority. However, this culture is undergoing transformations towards acceptance of the importance of family life for both female and male surgeons.

Male nurses also experience the influence of gender on the macro level. The most remarkable example of it are stories of men who did not even think of becoming nurses due to the absolute cultural non-acceptance of this profession for men and a real risk of isolation: nursing was out of their imagined possibilities. However, the shift towards greater acceptance of different types of masculinities, along with such external factors as professionalisation of the nurse's role, its stability in the context of economic crisis and neo-liberalisation, reduction of workplaces in traditionally masculine professions like mining and factory work, made it more attractive for men and brought it into the range of choices available to them in terms of cultural acceptance.

Summarising the results of the conducted study and in an attempt to give a short answer to the research question I would formulate the following gist. For female surgeons their gender plays a significant and prominent role in their professional lives: it shapes the development of their careers, influences their relationships and remains something they are almost constantly aware of in the professional settings. For male nurses, gender plays a more inconspicuous role: it sometimes shapes the set of professional and social tasks that they are expected to perform, they are somewhat "on guard" of their masculinity, however, they do not treat their own gender as something significant neither for their professional lives nor for people around them; their careers seem to be uninfluenced or, to a certain level, even advanced by their gender.

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Appendix A. Interview guide (before the pilot interview)

Block 1. Introduction

Introducing myself and purpose of my research, reading out the consent form, informing about principles of anonymity, voluntary participation, recording etc., receiving consent to participate and record.

Block 2. Receiving education and entering profession

Warm-up question:

- What is your specialisation within nursing/surgery?
- What is your current position in the hospital?

Path to the profession:

- When was the point when you chose nursing/surgery?
- Could you please shortly describe your educational path?

If choice about male dominated specialisation was made before education:

- How would you describe your educational experience? (*if difficult*: was it positive/negative? Was it hard? In what way? Do you think it was so because you are a man/woman?) How does it relate to your expectations?
- If compare that to your female/male peers, do you think they had similar experience? (if no: In what way was their experience different?)

If choice about male dominated specialisation was made during education:

- Do you think the educational process influenced your choice of specialisation? In what way?
- Did you feel any doubts about choosing your specialisation because you are a man/woman?
- How would you describe your educational experience after choosing your specialisation? (*if difficult*: was it positive/negative? Was it hard? In what way? Do you think it was so because you are a man/woman?) How does it relate to your expectations?
- If compare that with your female/male peers, do you think they had similar experience? (if no: In what way was their experience different?)

Relationship with peers: How were your relationships with peers? Why do you think it was as such? Do you think it was as such because you are a man/woman? Were there many men/women in your specialisation?

Relationship with educators: How were your relationships with professors and mentors? Why do you think it was as such? Do you think it was as such because you are a man/woman? Were there many men/women among your professors or mentors? Did you have role models? Who were they?

Block 3. Career path

Overview:

- Could you please shortly describe your career path that has led you to your current position?

Recruitment:

- Speaking about recruitment process, could you please describe how does it normally goes for you (*if difficult*: what questions are you normally asked? What is the attitude towards you in general?)?
- If there were some unusual moments in the recruitment processes you can recall, could you please describe them?

Changing job:

- Could you please tell me whether you have ever changed a workplace? (*note:* cases when you changed job not because you finished training and had to move on to the next step)

if yes:

- Could you please recall what were the reasons why you decided to change the job? Do you think your decision was connected to the fact that you're a male nurse/female surgeon in any possible way? (*if yes:* Do you know of any case when a male nurse/female surgeon decided to change their job for the same reason? (*if yes:* Could you please talk about such case in more detail?))
- Have you ever faced difficulties in finding a job? (*if yes:* please specify what difficulties did you face. Do you think it was connected to the fact that you're a male nurse/female surgeon? (*if yes:* Do you know of any case when a male nurse/female surgeon also faced difficulties in finding job? (*if yes:* Could you please talk about such case in more detail?)))

Promotion:

- Could you please tell me whether you have ever been promoted? (*if yes:* Do you think there were other than professional reasons for this promotion? Did you ask for the promotion?)
- Have you ever been denied a promotion? (*if yes*: please tell how the denial was explained to you?)
- Could you please tell me whether you have ever been transferred to a position of similar level? (*if yes:* Do you think there were other than professional reasons for this transfer? Did you ask for the transfer? (*if yes:* why?))
- Have you ever been denied a transfer to the position of similar level? (*if yes*: please tell how the denial was explained to you?)
- Could you please recall if you've ever rejected an offer of promotion or transfer to another position of similar level? (*if yes:* Why? Why do you think you were offered this promotion/transfer?)
- What do you think are the experiences of other male nurses/female surgeons with promotions and transfers? Do you think they are similar to yours? Do you

think they are similar to the experiences of female nurses/male surgeons? (*if no:* in what ways are they different?)

Block 4. Relationship with superiors, subordinates, colleagues, patients and "outsiders".

Relationship with colleagues:

- Could you please tell me more about your colleagues: is your department big? Are there any men/women?
- How would you characterise your relationship with colleagues (*if difficult:* is it purely professional or do you consider them friends, for example? Do you spend time together outside working hours?)
- Do you think that your female/ male colleagues have different type of relationship with other colleagues? (*if yes:* in what way is it different?)
- Do you think that female/male colleagues have different attitude towards you, not like towards your female/male colleagues? (*if yes:* how is it expressed?)

Relationship with superiors:

- Could you please tell me more about your superior: who are they within the hospital? Are they men or women?
- How would you characterise your relationship with them?
- Do you think that you are treated differently compared to your female/male colleagues? (*if yes:* how is it expressed?)

Relationship with patients:

- How would you characterise your relationship with patients?
- Do you think that patients have different attitude towards you, not like towards female/male colleagues? (*if yes*: how is it expressed?)

Relationship with "outsiders":

- How do you feel when you mention your profession to someone outside the hospital? Why? Do you think that your emotions in these situations are different from your female/male colleagues? (*if yes:* in what way?)
- Was there ever a situation when you decided to hide information about your profession? (*if yes:* why?)
- Could you please describe people's reaction when they hear that you are a surgeon? Do you feel comfortable with this reaction? Do you think this reaction is connected to the fact that you are a male nurse/female surgeon? Is there any difference in reaction coming from men and from women?

Appendix B. Consent Form

This study looks to understand factors that influence work- and education-related experiences of female surgeons and male nurses in the United Kingdom and Republic of Ireland.

<u>If you are willing to participate in this interview, please read the following statements and sign below:</u>

- **I understand that my participation is voluntary and that I am free to withdraw my data without giving any reason prior to publication**
- **I understand that my answers to this interview are confidential**
- **I understand that neither myself nor my organization will be identified in any output from the study.**
- **I understand that an anonymised dataset from this study may be used for future research purposes**

If you have any questions or concerns about the research, please contact the Researcher – Olga Temina (olga.temina364@gmail.com)

or the Supervisor – Dr Vladymir Ilin (ivi-2002@yandex.ru).

If you agree to take part in this study, please sign below:

Informant:

Signature: **Date:**

Researcher:

Signature: **Date:**

Appendix C. Information Sheet

Research project: "Male and Female Medical Workers Occupied in Non-Traditional Professions in United Kingdom and Republic of Ireland: Biographical Analysis of Their Careers"

Invitation and Brief Summary

This study looks to understand factors that influence work- and education-related experiences of female surgeons and male nurses in the United Kingdom and Republic of Ireland. The research is conducted by Olga Temina, student of Saint-Petersburg State University. The supervisor of this research is Dr Vladymir Ilyin, Professor of Sociology at the Department of Sociology of Culture and Communication, Saint-Petersburg State University.

If you agree to take part in the interview, you will be asked to answer a number of questions related to your work and education experience. The interview will be conducted via Skype and will take between 30 to 45 minutes.

In the beginning of the interview you will be asked if you allow the researcher to record it. If you agree to be recorded you may ask to pause the recording during certain answers or stop the recording completely at any point of the interview.

Do I have to take part?

No. It is entirely up to you whether or not you choose to be involved in the study. If you do decide to take part, you will be asked to sign a consent form to confirm that you are happy to be involved. You may stop your participation at any moment without giving any explanation to that. You may withdraw any data you provide prior to publication, by which time all data will be analysed and fully anonymised. To withdraw your data, please contact the Researcher by email: olga.temina364@gmail.com

Will my taking part in the study be kept confidential?

Any information collected will be kept strictly confidential and will not be disclosed outside the research team (Researcher and Supervisor). Any personal information that will be collected will only be used for the purposes of the research. You have the right to check the accuracy of the data collected and to correct any errors. You will not be able to be identified in any report or publication about the project.

What will happen to the results of the research?

The results of this study will be used for MA thesis of the Researcher and may be published in academic journals and presented at conferences, but individuals and organisations will not be identified in any publications. A summary of the results will be made available to you if you would like to receive it at the end of the study.

If you have any questions, concerns or cause for complaint:

Researcher: Olga Temina

E-mail: olga.temina364@gmail.com

Supervisor: Dr Vladymir Ilyin

E-mail: ivi-2002@yandex.ru

Thank you for taking the time to read about the study

Appendix D. Pseudonyms of the participants

Pseudonyms of the participants

Pseudonyms	Position	Specialisation	Country
SG1, Consultant, Ireland	Consultant	General (Colorectal) Surgery	Republic of Ireland
SG2, Post-FT2, UK	Clinical Teaching Fellow (post-Foundation Training Year 2)	N/A	United Kingdom
SG3, ST7, UK	Specialty Surgical Trainee Year 7	Trauma and Orthopaedics	United Kingdom
SG4, Consultant, UK	Consultant	Gynaecologic Oncology	United Kingdom
SG5, Post-FT2, UK	Junior Doctor (post-Foundation Training Year 2)	N/A	United Kingdom
SG6, Consultant, Ireland	Consultant	General (Upper Gastrointestinal) Surgery	Republic of Ireland
SG7, 3rd -year medical student, UK	3-rd year medical student	N/A	United Kingdom
SG8, Consultant, UK	Consultant	General (Colorectal) Surgery	United Kingdom

NS1, CNM3, Ireland	Clinical Nurse Manager 3	Psychiatric nursing	Republic of Ireland
NS2, CNM2, Ireland	Clinical Nurse Manager 2	Children's Nursing (Theatre)	Republic of Ireland
NS3, NQ Nurse, UK	Newly Qualified Nurse	Oncology Nursing	United Kingdom
NS4, Matron, UK	Matron	Registered Nurse	United Kingdom
NS5, NQ Nurse, UK	Newly Qualified Nurse	Registered Nurse	United Kingdom
NS6, ANP, Ireland	Advanced Nurse Practitioner	Urology Nursing	Republic of Ireland
NS7, CNM2, Ireland	Clinical Nurse Manager 2	Children's Nursing (Diabetes)	Republic of Ireland

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