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## Doing and Undoing Gender in the Hospital Workplace

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The goal of this article is to examine the nature of gender stereotypes in the hospital workplace, and how they affect the work lives of doctors in the hospital workplace. We illustrate how stereotypes are internalised, practised consciously and unconsciously and resisted by doctors in Italy. We hope to demonstrate that gender stereotypes are prevalent in the hospital workplace which affects the everyday working relationships of doctors, particularly female doctors in their interactions with colleagues, patients and nurses.

Several empirical findings and theoretical concerns have influenced the way we approached this work. First, gender biases faced by female employees have been central issues in contemporary research. In the largely male-dominated medical profession, women have a slower career progression than men (Reed and Buddeberg-Fischer 2001; Glover 2002; Crompton and Harris 1998) because they face gender-based disadvantages. Accordingly, we wanted to capture the day-to-day instances of how doctors, particularly women encountered disadvantages or biases due to gender stereotypes in the hospital workplace. Second, we work from the theoretical assumption that gender stereotypic traits are enshrined in socio-cultural values, leading men and women to believe in and internalise these values (Miyake *et al* 2010), but we wanted to see how, and to what extent gender stereotypical traits were practised, performed or resisted by doctors everyday at the hospital workplace. Third, the fundamental objective of the current project is to gain knowledge about how male and female doctors experience gender stereotypes at the hospital, particularly in the context of Italy where there is a lack of sufficient research that investigated the role of gender stereotypes in the hospital workplace. We seek to inform both researchers and policy makers not only from within Italy but to be of relevance for those interested in how gender stereotypes affect the everyday work lives of doctors.

### **Gendered Hierarchies at Work**

In male-dominated professions, a woman's status is seen as lower than a man's (Eagly and Karau 2002). Men are evaluated as performing better at medical work than women (Allen 2005; Carnes *et al* 2015). Attribution of greater status and competence to men over women create underlying hierarchies of gender. These underlying conceptions of gender hierarchies mean that men are implicitly preferred for competition and high-status positions, which in turn have negative implications for female doctors.

On an everyday basis, female doctors are expected to be twice as good as their male counterparts (Bright *et al* 1998; Moss-Racusin *et al* 2012), and are mistaken for non-physicians (West 1984). The long-term consequences of gender disadvantages are that female doctors lag

behind men in career advancement, under-representation in prestigious specialties and lesser earnings or authority than men (Schmid Mast 2004; Crompton and Harris 1998; Gjerberg 2001).

Specialty choice in medical careers is strongly gendered (Gjerberg 2001), with women represented the highest in specialties such as paediatrics, obstetrics/gynaecology and the lowest in surgical subspecialties (Allen 2005; Riska and Wegar 1993). Prestigious specialties are dominated by men and less prestigious by women (Lemmp and Seale 2006; Reed and Buddeberg-Fischer 2001). However, some studies conducted in Scandinavian countries did not detect differences in specialty choices by gender (Diderichsen *et al* 2013; Gjerberg 2001). It is not known whether male doctors face gender-based disadvantages at work.

Apart from gender and specialty, age is important in reinforcing gender stereotypes and creating disadvantages for women in the workplace (Posthuma and Campion 2008; Duncan and Loretto 2004; DeArmond *et al* 2006). Men and women do not receive equal support from older colleagues in the medical profession (Jefferson *et al* 2015). There is a need to find out if other factors besides gender, such as age, might play an important role for doctors' careers in the hospital workplace.

### **Performing Gender Stereotypic Traits**

Gender stereotypes set the 'do's and don't's' of masculinity and femininity. Gender stereotypic traits affect the jobs or activities performed by men and women, for example, technological skills with men, and domestic skills with women (Bem 1977). Some masculine stereotypical traits are: aggressive, assertive, competitive and dominant among others. Feminine stereotypical traits are: affectionate, cheerful, compassionate, understanding and warm (Bem 1977; Prentice and Carranza 2002).

Gender stereotypes also define socially undesirable traits, i.e., the social appropriateness of a man demonstrating feminine traits or a woman showing masculine traits (Stoppard and Kalin 1978). Although the increasing presence of women in traditionally 'masculine' jobs is reducing the perceived 'unnaturalness' of women in these job positions (Eagly and Karau 2002), women feel the need to display masculine characteristics when working in male-dominated jobs (Carnes *et al* 2015). When female doctors do not exhibit masculine traits at work, their progress into leadership positions is slow (Carnes *et al* 2015; Burgess *et al* 2012). However, women need not give up their feminine traits entirely, in order to be perceived as leaders. Some studies suggest that it is possible for women to seem capable leaders with a combination of feminine and masculine traits (Eagly and Karau 2002; Isaac *et*

al 2010) even though others suggest they cannot do so successfully (Rudman and Glick 2001). It is unclear the processes by which female doctors manage to reconcile their masculinised professional capabilities with their feminine identities.

While most gender stereotypes are clearly visible, studies talk about ‘gender blindness’ in academic medical careers where biases faced by women are not ‘visible’ (Hamberg 2008; Miyake *et al* 2010). This suggests that there is a need to uncover the invisible/unconscious gender stereotypes that are practised in the daily lives of doctors at the hospital.

Apart from some studies that talk about doctor-nurse relationships and how gender affects female doctors (Davies 2003; Gjerberg and Kjolsrod 2001), few empirical studies explore how female doctors navigate gender stereotypes. A greater understanding of the everyday workplace relationships of doctors that are fraught with gender stereotypes, is needed. With the current body of literature focusing on the gender stereotypes faced by women, there is a need for examining how gender stereotypes may also affect male doctors.

### **Gender in Medical Careers: The Context of Milan, Italy**

The current literature on gender stereotypes in medical careers is dominated by empirical studies conducted in the UK, US and Scandinavian countries (Gjerberg and Kjolsrod 2001; Carnes *et al* 2008; Cassell 1997) with a serious gap of sufficient literature outside these regions. If the problem of gender stereotypes is not studied in different settings, it is far from being addressed, and hence the importance of more research in this area to see firstly, if the situation since has changed, secondly, the layered complexities of a different socio-cultural setting and thirdly, laying the groundwork for pinpointing problems faced by female and (without excluding) male doctors as the starting point for improving their work lives.

The fieldwork area for this research was conducted in Milan, Italy. The reason why Milan in Italy was considered for this research study is at once, attributed to a generalised yet specific context. The public-private debate continues to be relevant in Italy. In Italy, domestic responsibilities are a woman’s domain and gender inequality persists through an unequal distribution of housework and child rearing that fall primarily over a woman (Mencarini and Sironi 2010). Female doctors in Italy face disadvantages in their career advancement, struggling to improve their work-life balance, social networking and under-representation in specialisations (Spina and Vicarelli 2015; Vicarelli 2003; Andreotti and Crea 2005; Modena *et al* 1999). While some empirical studies in Italy discuss gender stereotypes in the media and sports professions (Furnham and Voli 1989; Lauriola *et al* 2004; Capranica and Aversa 2002), gender stereotypes that prevail in the hospital workplace need to be studied to understand how

they contribute towards the formation and practice of gender stereotypes in the medical profession in Italy. According to SHE figures (2015), in the government sector, the proportion of female researchers in the medical sciences is quite high, at 53 percent in 2012. However, when seniority levels are compared by gender, the number of senior academic staff for female doctors is six times lower than male doctors (SHE figures 2015). Overall, female doctors are under-represented, and within Europe, Italy is placed among the lowest with female doctors at 40.29 percent (OECD 2016). Some empirical studies in Italy found that female doctors were disadvantaged, experienced greater mental stress and lesser job satisfaction (Magnavita 2013) and a lack of career advancement opportunities available to men, such as absence of female role models and difficult work-family balance (Andreotti and Crea 2005). The importance attached to age seniority was found to be relevant for promotions and a disadvantage for women (Modena *et al* 1999). Even though some studies (Kinzl *et al* 2007; Davies 2003) outside Italy have somewhat considered the importance of age in workplace and power relations, age as a factor has not been explored in the understanding of gender stereotypes at the hospital workplace, and it would be interesting to examine if age plays a role in defining gender stereotypes in the Italian context. More work needs to be done in this region to fully comprehend the level of gender disparity and its contribution toward gender stereotypes, if any, and to what extent, the current literature would be supported by such studies.

Career opportunities vary according to the regional context of Italy. In the Italian labour market, women have lesser career opportunities than men, in terms of income, but also career disparities in terms of equal opportunities are greater in South Italy than in North Italy (Checchi and Peragine 2010). The structural disparities between North and South Italy in terms of gendered disparities are rooted in higher education and sustained until an individual's entry to the labour market (Checchi and Peragine 2005). North Italy has traditionally been more progressive than South Italy in several aspects, such as education, income and employment opportunities for men and women (Barbieri and Scherer 2009; Materia *et al* 2005; Lynn 2010; Alesina *et al* 2001; Tabellini 2010). Cultural differences of kinship, social networks and gender discourses prevail between Northern and Southern Italy (Hollinger and Haller 1990; Ruggiero *et al* 2000; Bernardi 1998; Krause 2001). In terms of human development indices, a wide North-South divide is evident. In North Italy, the Lombardy region stands out as one of the most productive, dynamic regions having higher ratings in education, job and empowerment than not only South Italy but also other Northern regions, such as Emilia Romagna or Veneto (Costantini and Monni 2006). This puts the Lombardy region in a unique position, which would

enable us to see how one of the most prosperous regions of Italy (France *et al* 2005) fare in terms of gender equality.

Modelled on the British National Health Service, Italy's national health service (Servizio Sanitario Nazionale – SSN) shares healthcare responsibility between the State and its 20 regions. Within Italy, the hospital sector accounted for approximately 48 percent of public expenditure. However, with a clear north–south divide, regional disparities in economic power and healthcare infrastructure exist. The Lombardy region is the richest, to where residents from southern regions travel for better health care (France *et al* 2005).

The city of Milan is the financial nerve centre in Lombardy, contributing immensely to trade and commerce, and holding ground as the finance capital of not only Lombardy but the whole of Italy. The history of women working outside their homes in Milan can be traced to the time of the early 1900s when women followed doctrines of the Catholic Church that they should be focused on their family. This changed with the emphasis on socialism which led women to work outside their homes in factories, freeing them from the burden of household duties (Foot 2009). By the 1990s, a shift began in the public discourse about the necessity of women-friendly policies in Italy, but these policies were not properly implemented (Naldini and Saraceno 2008). In the current labour market, a deeper understanding of how gender affects the everyday organisational practices in the experiences of doctors working in Milan, decidedly one of the most prosperous and progressive cities in Italy, is needed.

## Methods

We undertook the present project to better understand how doctors experience gender stereotypes and the processes by which women navigated these challenges in the hospital workplace. We were particularly interested in eliciting the views and experiences of male and female medical doctors working in hospitals, on the role of gender and how they negotiated gender stereotypes in their everyday lives. Our broad research questions included the following questions: (i) the nature of work background and career achievements (ii) nature of advantages or disadvantages faced at the workplace due to gender (iii) nature of professional relationships (iv) role of gender in specialties. The questions aimed to find out how men and women defined their own work, to see if there were similarities or differences in the way each expressed about their work, seeking to make 'visible' the stereotypes underneath work experiences, the nature of professional relationships between doctors, patients and nurses and finally, the role of gender in stereotyping specialties within the workplace.

This study conducted interviews with medical doctors based in Milan, Italy. We conducted in-depth, one-on-one interviews with a sample of 41 medical doctors. This study was undertaken in two public hospitals of Milan. Similar in institutional style and structure, both hospitals were state-funded public institutions, specialised day hospitals and research centres of excellence in their respective specialised areas. Medical doctors from both hospitals were affiliated to the public network Fondazione IRCCS (Istituto Di Ricovero e Cura a Carattere Scientifico) approved by the health wing of Lombardy Province. Doctors were recruited across a range of specialisations (Surgery, Gynaecology and Obstetrics, Neurology, Paediatrics, Pathology, Medical Oncology, Histology, Radiology, Haematology, Anaesthesiology). All participants were white Europeans, aged from 28 to 65. 20 were male doctors and 21 were female doctors. 4 doctors declined to participate in the study for a variety of reasons. An additional 15 interviews were conducted with doctors to see if any more new information emerged, and although they did not yield anything new, it served as a way of ‘triangulating’ the interview data (Lincoln and Guba 1985).

To recruit participants, emails were sent to doctors working in the hospitals. With the help of the hospital administration, we invited hospital doctors throughout all specialisations, for an interview. We also interviewed doctors, not organised through hospital administration but those who volunteered to participate through our initial contacts.

The study information sheet, informed consent and interview topic guide were developed in accordance with ESRC guidelines (ESRC 2015). Each interview lasted approximately 1 hour and centred around four broad questions, with probes at various stages during the interview. Pre-determined questions, formalised in interview schedules, were kept to a small number, so that topics that arose during the interviews, would aid in guiding the discussion. The resultant interviews are therefore, best described as semi-structured. An attempt was made to keep interview questions quite general, as a deliberate strategy to elicit responses that avoid ‘contrived’ data derived from interviews with rigid, pre-set agendas and instead focus on participants’ ‘everyday’ understandings as ‘records of natural interaction’ (Speer 2002; Potter and Wetherell 1995). There was a great deal of flexibility included in the topics so that discussions could emerge ‘naturally’ (Speer 2002).

Field notes were kept through the different phases of data collection and analysis. Interviews were primarily collected in English, but participants occasionally expressed in their native tongue. In such cases, translations were completed to retain authenticity of the spoken word. All interviews were audio-recorded and transcribed verbatim.

After transcription and data cleaning, interviews were de-identified and participants assigned pseudonyms. Thematic analysis, including data familiarisation, line by line coding and collation of codes into thematic clusters was completed (Braun and Clarke 2006; Miles and Huberman 1994).

### **Unconscious Internalisation of Gender Stereotypes**

Participants unconsciously internalised gender stereotypic beliefs in their speech and thought. Women sought to ‘hide’ their achievements whereas men wanted to ‘show’ their successes. This reluctance to claim their achievements as well-deserved was evident in the way female doctors would, after stating their achievements, add, ‘I am lucky’ or ‘I have been very lucky’. Female doctors undervalued their achievements and did not attribute it to their own merit, but to external factors, such as a supportive partner, or work colleagues; i.e., their ‘luck’. While external support may indeed have contributed to career achievements for female doctors, it was telling that male doctors did not similarly acknowledge that ‘support’ or ‘luck’ when it came to their career achievements.

Because ambitiousness is a valued masculine trait and modesty is a desirable feminine trait (Prentice and Carranza 2002), female doctors performed feminine stereotypic traits of humility regarding their achievements. Similarly, male doctors adhered to masculine traits by speaking about their successes without discomfiture or hesitation.

Unconscious internalisation of gender stereotypes further became ‘visible’ when doctors spoke about under-representation of female surgeons. Female doctors themselves felt that this was due to gender-based obstacles, such as work-family balance. Male doctors, however, felt that surgery as a specialty was ‘risky’ for women because surgeons were more liable than other doctors to be sued and be involved in legal cases. It was a revealing explanation because this supposed incapability of women in efficiently handling legal cases was given only by men, not by women themselves. This reflected unconsciously held gender stereotypes of men being more rational and risk-taking (stereotypic masculine traits) than women, implicitly meaning that surgery as a specialty was less suited to women than men.

### **Stereotyped and Reverse Stereotyped Specialties**

Certain specialties were associated with women and others with men. Male-dominated surgical specialties such as cardiothoracic or neurosurgery had greater competition and prestige at the hospitals. In comparison, female-dominated specialties such as pathology or



microbiology were considered less competitive, and hence, less prestigious. Elements of prestige were involved even within sub-specialties.

*Men take the big, important body parts and women specialise in very specific, small parts. The job that women do is also very important, but it is not as prestigious. Women work mostly in paediatric or child surgery. (Valeria, early 30s, surgery)*

If surgery was associated with male doctors, gynaecology was associated with female doctors. Patients tended to prefer male gynaecologists for surgical operations, and female gynaecologists for routine examinations; thereby stereotyping both male and female doctors.

*Some patients are shy. They request that only female doctors should touch them. But male doctors are equally professional... (Silvia, late 30s, gynaecology)*

Female patients that requested for female gynaecologists exhibited stereotypically feminine traits of 'modesty' during their gynaecological visits. Likewise, doctors too performed their normative gender roles by not judging those patients that requested female gynaecologists, by instead, unconsciously condoning the exclusion of male gynaecologists.

*There are male surgical gynaecologists, for surgical cases. In medical gynaecology, we mostly have women. It is good for patients because many women prefer that a woman (female gynaecologist) should examine them. (Giulia, late 40s, gynaecology)*

Preference for female gynaecologists perpetuated a reverse gender stereotype where female doctors were preferred over male doctors by patients. When patients requested for female over male gynaecologists, doctors accepted such requests as routine and did not typically defend the capability or professionalism of their male colleagues in front of patients.

### **Double Standards of Gender Stereotypes**

According to gender role stereotypes, men are supposed to be career-oriented, not family-oriented (Trapnell and Paulhus 2012). When male doctors prioritise family, they do not conform to 'masculine' gender role expectations. Non-conformity to normative gender roles in the hospital workplace can invite backlash effects, with penalties ranging from mild ridicule to exclusion from important career opportunities.

*I was packing things into the car and my wife and daughter were ready to get into the car. Then I got a phone call and I was asked to go to the hospital. I had to cancel the family trip... my daughter was really disappointed. But you cannot say these things to your colleagues; otherwise they will make fun of you. You are not supposed to be so devoted to your family. A woman can say these things, a man cannot. (Alberto, mid-40s, surgery)*

As a male surgeon, Alberto was unable to express his disappointment as that would mean he was family-oriented, a 'feminine stereotypic trait' which did not conform to his normative gender role. However, the same gender stereotypes allowed female doctors to speak about family at work. Camilla, a radiologist in her mid-50s, who had to look after ageing parents, openly discussed her family obligations with colleagues at work. Similarly, Barbara, a histologist, had a young child to care for at home, due to which her supervisor allowed her certain exemptions, such as going home early.

*Dr. (-) knows that I have a daughter. She understands that my daughter needs me at home, and allows me to go home when I need to, or come to work a little late sometimes. She's very understanding. (Barbara, mid-30s, histology)*

As expressing emotions and being family-oriented adhered to traditionally feminine stereotypes (Prentice and Carranza 2002), female doctors did not face any backlash because they were conforming to 'feminine' gender norms.

Senior male and female doctors may perpetuate gender stereotypes to undermine a female doctor's capability by employing double standards and unconscious biases. For example, when mistakes were made, men were judged more leniently than women.

*I was new and had not yet learnt to perform a procedure. As soon as I made a (particular) mistake, a senior female and a senior male doctor shouted and insulted me in front of everyone – doctors, nurses, everyone. But (a few days) later, when my male colleague too made that very same mistake, nobody scolded him. The male surgeon explained the procedure to him in a friendly way. And the female surgeon was encouraging him, constantly telling him that it was only his first time. (Valeria, early 30s, surgery)*

## **Power Dynamics of Gender and Age**

In general, male doctors commanded more authority than female doctors whilst doctors belonging to higher age-groups commanded more authority than those from lower age-groups.

*Children can get very noisy sometimes. They don't realise how sick they are ... Sometimes, I go to their rooms to ask them to calm down or be quiet. Just two days back, I went to a room, requested the parents to lower the television volume. They kept sitting on the bed and did not even acknowledge me. But when a male nurse entered the room and told them the same thing - they stood up when he walked in and immediately lowered the volume. This kind of situation has happened many times. (Claudia, 28 years, paediatrics)*

Patients tended to respect men (male doctors or male nurses) as authority figures over female doctors, particularly young female doctors. Such confusion in the minds of patients over who wielded authority is reminiscent of the aeroplane workplace, where passengers respect male stewards over female air-hostesses and recognised the former as authority figures, despite stewards being lower down the hierarchy than air-hostesses (Hochschild 2012). Similarly, at the hospital workplace, a young female doctor's authority can be undermined due to age and gender stereotypes that foregrounded respect for authority to the old over young and male over female.

In the hospital power dynamics, the masculine gender is favoured, and age accentuates the bias when a doctor is young. For example, while senior female doctors are respected over junior male doctors, a senior male doctor would command greater authority than a senior female doctor.

A female doctor's authority and competence may be undermined by nurses too. There was an undercurrent of conflict and tension between senior, experienced nurses and young doctors, particularly female doctors, when sometimes senior nurses would find fault in the professional abilities of young, female doctors.

*One day I was filling out a chart after a consultation. She (senior nurse) took one look at the sheet, tore it into pieces and threw it into the bin. She said rudely that I can't do even this little thing and told me to re-do it. (Silvana, late 30s, oncology)*

*Sometimes, senior nurses do not take the advice of junior doctors seriously, even if they (the latter) are correct. (Serena, early 30s, neurology)*

Age stereotypes play out in the hospital workplace when some doctors prefer working with doctors of a similar age group.

*I have worked with many doctors ... but I have noticed that young doctors are too proud; they think they know a lot. Older doctors are more knowledgeable in my experience and it is easier to work with them. (Rinaldo, 60s, haematology)*

Age stereotypes were held by older against younger employees and vice-versa. In-group age bias can create tensions of power and authority between doctors.

*Older doctors tell you, 'come here, do this, do that'. I am not their servant. Because I am young, they do that. Sometimes they look at the database and call you on the phone to discuss. If they don't understand something, they call you upstairs (to the medical/surgical departments). Young doctors always come downstairs, chat with you and are friendly. They are nice. (Manuela, early 30s, radiology)*

Gender stereotyping also shaped patients' stereotypical assumptions. Patients frequently assumed that 'women are nurses' and 'men are doctors'.

*The (male) patient addressed me as 'Signora' (Madam) ... meaning a nurse. But my (male) colleague, standing beside me, was addressed as a 'Doctor'. (Silvana, late 30s, oncology)*

Female doctors reacted differently when recalling such situations. While most did not appreciate their authority being undermined, some took such incidents lightly or laughed about it privately with their colleagues. Others were empathetic. Empathy and warmth are feminine stereotypic traits and some female doctors internalised these traits by acting according to normative gender roles.

When female doctors were assigned to older male patients, patients sometimes directly asked questions such as, 'Can I please request a male doctor?' The public nature of their jobs demanded that no matter how irritated or offended female doctors would get, they did not

publicly react rudely. This required a reconciliation with ‘how they actually felt’ (deep acting) versus ‘how they feel they should act’ (surface acting) and such a performance of ‘emotional labour’ created feelings of anger and / or guilt within the minds of some female doctors (Hochschild 2012). Male doctors were supportive towards their female colleagues in such instances.

*A few times, this happened to me. But my male colleagues, whoever was present at that time, would always explain to the patient that ‘Look, she is also a doctor. We have the same qualifications’. Once a male doctor explains like that, patients don’t question.*  
(Paola, mid-40s, surgery)

During the interviews, male doctors reacted more severely toward such obvious gender bias than female doctors. Male doctors did not laugh away such prejudices, instead even expressing annoyance or disdain towards such patients.

*Whenever patients say such things, I always explain to them that there is no difference.*  
(Federico, early 40s, surgery)

Strong and firm defence of their female colleagues usually deterred patients from further questioning a female doctor’s capabilities. While women did not actively seek such interventions from male doctors, they welcomed them. Even so, some patients were not always convinced but refrained from making further comments on a female doctor’s competence.

*Sometimes they are not convinced even after a (male) doctor explains, but they are afraid to ask again.* (Cecilia, late 30s, surgery)

Whenever a male doctor defended his female colleague’s capabilities, his word was respected. A man’s word is enough to silence a doubtful patient and is more authoritative than a woman’s. Such instances not only highlight the stereotypes within the medical profession, but also reflect cultural gender norms and gender stereotypes where a man’s authority is more easily accepted than a woman’s.

Despite some male colleagues standing up for their female colleagues, female doctors overwhelmingly felt that they had to work ‘twice as hard’ than male doctors, or that they had to ‘prove’ themselves.

*Women have to prove themselves at work. (Marta, early 50s, anaesthesiology)*

### **Practice, Performance and Resistance of Gender Stereotypes**

In response to being gender stereotyped as ‘nurses’ instead of ‘doctors’, or mistakenly being perceived as less competent than male doctors, female doctors adopted strategies of: (i) ‘behaviour’ and (ii) ‘appearance’ (Goffman 1978) by presenting themselves through these two aspects.

#### **Behaviour**

As a behavioural strategy, young female doctors would smile less frequently at their first meeting with patients. A lack of friendliness implies a business sense which is a stereotypical male trait (Prentice and Carranza 2002). Serena, a neurologist explained how she executed her behavioural ‘method’ with patients.

*When I enter a room, I first introduce myself as a doctor. During introduction, I do not smile. I am serious. Then I start talking to the patient. In the next few meetings with the patient, I may occasionally smile, but on the first meeting – never! It is very important to not smile during the first meeting. (Serena, early 30s, neurology)*

It was also important that a female doctor should introduce herself as one instead of waiting for the patient to assume, and not leave any room for misconceptions about female doctors’ identities.

*Sometimes it used to happen that I would talk with patients for long, discuss their treatment... at the end, they would ask me, ‘But madam (signora), excuse me, I would like to speak to the doctor please’. Then when I say that I am the doctor... not good... Some say, ‘Oh but you are so young’. Others want to talk to a ‘real’ doctor. That is why, in my opinion, the introduction is really important. (Serena, early 30s, neurology)*

Female doctors managed their behavioural interactions with patients through ‘first impressions’ that were acted out and performed in front of the patient (Goffman 1978). By adopting behavioural strategies, young female doctors resisted being gender stereotyped.

Older female doctors, particularly surgeons, acted and behaved ‘like men’. Senior female doctors spoke about the importance of appearing ‘less emotional’ and to ‘be like a man’ to advance in their careers. The prized qualities for senior female doctors were masculine traits. They strongly believed that ‘women should leave behind their family’ and femininity when they came to work.

*Women have to be tougher to be taken seriously.. Should become more like men at work .. Less sensitive, less emotional. Women should be more detached and less emotional.*  
(Giovanna, late 50s, pathology)

*Women should be professional, like men, or more than men, to be taken seriously.*  
(Greta, mid-50s, neurology)

A common statement in the interviews was that a senior female surgeon is ‘like a man’. Many male doctors felt that female surgeons were more ruthless, competitive and aggressive than men.

*Men forgive mistakes more easily, they let some things go. Female surgeons do not forgive. They act like men. They are, in my opinion, more aggressive than men.*  
(Leonardo, 60s, neurology)

Senior female doctors in top positions constituted a miniscule minority. In order to be accepted as leaders, women attempted to act or behave like men by adopting masculine behavioural traits.

### **Appearance**

Even though neither hospitals had uniforms and enforceable dress codes for doctors, as an ‘appearance’ strategy, female doctors would sometimes voluntarily wear white coats to be seen in the ‘role’ (Goffman 1978) of doctors by patients and not be mistaken as nurses. They also paid attention to their make-up, shoes and accessories which formed part of their ‘appearance’.

*I used to wear sneakers when I first started work. But patients would always confuse me with a nurse. So I started wearing high heels and always, my white coat. No*

*jewellery, no heavy make-up. And after I began to dress like that, patients do not think I am a nurse or call me 'madam'. My male colleagues wear sneakers, but still no one makes that mistake with them. With women, it's different. (Cecilia, late 30s, surgery)*

While male doctors did not have to experience gender bias because of their behaviour or appearance, female doctors learned to adopt various such strategies in order to cope with, and resist the unfair gender stereotyping of their identities and capabilities.

### **Discussion and Conclusions**

In this paper, we explicated how gender stereotypes are utilised and experienced by both male and female doctors in their 'everyday' work lives. Many studies have made this argument of gender stereotypes being practised in different organisations (Isaac *et al* 2010; Schmid Mast 2004) but few examined the interplay of interactional and intersectional dynamics between doctors, nurses and patients and study these discourses at the hospital workplace. Some studies (Davies 2003; Gjerberg and Kjolsrod 2001; Carnes *et al* 2008; Eagly and Karau 2002; Cassell 1997), conducted primarily in the US, UK and Scandinavian countries, are notable exceptions and our study builds upon this research by showing how doctors practice, reinforce or counter gender stereotypes, and manage their professional vis-à-vis gender identities in Italy.

Matching some literature, patients frequently assumed 'women are nurses' and 'men are doctors' (Davies 2003; West 1984; Cassell 1997) and female doctors felt they had to 'prove themselves' at work (Bright *et al* 1998; Moss-Racusin *et al* 2012). But overwhelmingly our findings demonstrate the pervasiveness of internalised gender stereotypes where doctors unconsciously perform and practice stereotypical gender traits. By conforming to gender stereotypical traits, both male and female doctors were 'doing gender' (West and Zimmerman 1987). As 'actors' performing roles in front of patients, female doctors were also 'undoing gender' (McDonald 2013; Deutsch 2007) by managing their behavioural interactions with patients through 'first impressions' (Goffman 1978) or 'acting like a man' in order to be taken seriously as doctors. In the hospital workplace, female doctors feel the need to masculinise themselves to be perceived as legitimate doctors. This leads us to the proposition that the medical profession is itself masculinised, and women and femininity appear to be out of place, and do not fit into the perceptions of what a doctors should look like. Female doctors 'fit' into caring roles; caring being another gender stereotypical trait (Bem 1977). Hence female doctors



are accepted more easily in roles where traits of femininity are acceptable and valued. For example, in the hospital, female doctors are more easily accepted as paediatricians than surgeons, because a stereotypical woman is more ‘child-like’ or ‘caring’ (associated with paediatrics) whereas a stereotypical man possesses more ‘mechanical’ or ‘technical’ skills (associated with surgery). However, when authority and power dynamics are also taken into account, a female doctor is taken more seriously if she ‘acts like a man’. This is because power and authority as traits are associated with men and masculinity (Connell and Messerschmidt 2005). If the norms of the profession are such that men do not feel the need to ‘act’ whereas women do, this suggests that the norms are masculinised and biased against women and femininity. It also means that a great deal of time and energy (or ‘emotional labour’) is expended by women in exhibiting a portrayal of an ‘ideal’ that is essentially a masculine ideal, necessitating the elimination of feminine traits. On the other hand, because men and masculinity are associated with power, authority and being perceived as competent, male doctors do not need to expend ‘emotional labour’ in preparing for their roles as doctors by thinking about whether to ‘act like a man’ or ‘look like a doctor’. Men and masculinity are therefore, identified and associated with power, authority and competence in the hospital workplace. Masculinised norms at the hospital workplace came into force primarily because male doctors dominated the profession when norms were formed, and changes in these norms have been resilient even in the face of rising women in the labor force. Male doctors are not exempt from following masculinised norms at the hospital workplace. In management and other work organisations, not conforming to gender norms and stereotypes brings the risk of ‘backlash’ effects (Moss-Racusin *et al* 2010; Rudman and Glick 2001). Our findings from a different workplace setting, the hospital, show that male doctors faced ‘backlash’ effects of ridicule if they expressed the need for ‘family’ time, as it is not a ‘masculine’ trait. Understanding the full effects of masculinised workplace norms has immense policy relevance, and requires immediate institutional remedies, so that female doctors do not continue to face biases due to masculinised workplace norms. Hospital workplace norms should allow space for femininity and feminine norms so that female doctors are identified as doctors, and not devalued because of exhibiting stereotypical feminine traits. A policy shift would also mean that female doctors do not need to expend ‘emotional labour’ by preparing for the roles in terms of appearance and behaviour, and are enabled instead, to focus on their actual role as doctors in treating patients and improving healthcare.

Specialty of doctors play a role in gender stereotyping. Matching with the literature, certain specialties are male-dominated and others are female-dominated (Allen 2005; Riska

and Wegar 1993). Our study significantly found that there was a noticeable preference for male surgeons and female gynaecologists by patients. Requests for female over male gynaecologists were not viewed as gender bias, and treated as courtesies to be extended to patients. However, when patients requested for male over female surgeons, it would be seen as unacceptable and be met by a far more severe reaction. The difference in reactions points to the ongoing relative awareness about gender bias faced by women. But there also needs to be greater awareness about reverse gender stereotyping that may be faced by male doctors, not merely in female-dominated specialties such as gynaecology, but also in other areas of their work relationships, such as seeking a greater work-family balance.

Age plays an important, yet often overlooked role in gender stereotypes. Studies on management organisations show an in-group age bias (Posthuma and Campion 2008; Duncan and Loretto 2004). Albeit in a different setting (hospital workplace), a similar in-group age bias was seen in this study. In a study in the UK finance enterprise, both age and gender were found to be important in authority relationships (Duncan and Loretto 2004). This resonates with our finding in a different workplace setting; in hospital organisations in Milan, there was a complex web of gender and age dynamics, and young female doctors were undermined at work. As a consequence of gender stereotyping, unconscious biases and double standards prevailed. For instance, when mistakes were made, male doctors were judged more leniently than female doctors. This phenomenon of apportioning blame for mistakes more to women than men was found in another male-dominated workplace culture, i.e., police organisations (Parker and Griffin 2002).

Our study is limited by its focus on participants in a single location (Milan). Additional work should include male doctors' perspectives who face reverse gender stereotypes to understand how gender stereotypes affect both male and female doctors negatively. Policy makers should consider the emotional labour that doctors experience at their hospital with strenuous workplace relationships, the impact of their age, gender and specialty on their perceived competence, and how these evaluations of their capability could affect their overall work performance. Similarly, policy perspectives should examine how gender stereotypes are embedded within the hospital workplace – in the Italian setting, everyday practices of gendered behaviour are driven by a complex age-gender stereotypic intersection that does not prioritise the young, female doctors. Finally, we are cognisant about an implicit assumption in our argument that a fuller engagement with internalised/unconscious gender stereotypic practices within the hospital workplace will be of benefit to both male and female doctors. Future research should interrogate whether a more value-free, gender aware hospital work

environment would actually benefit the relationships of doctors with their colleagues, nurses and patients.

In summary, a disconnect exists between doctors' gendered identities and their masculinised/feminised work cultures (example, masculinised surgery and feminised gynaecology). Age and specialty contribute to an even more complex understanding of gender stereotypes. The 'emotional labour' or tussle that doctors experience while navigating gender stereotypes in interactions with doctors, nurses and patients does not, however, produce inertia. Instead, within this understanding, insights can be offered into how doctors unconsciously internalise and consciously subvert gender stereotypes, which can help us move towards reducing engagement with emotional labour and encouraging a policy shift of productive utilisation of doctors' skills and resources through greater gender awareness at the hospital workplace.

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