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Professional Paths and Occupational Segregation by Gender in the Healthcare Sector: A Qualitative Study on Medical Residents and Nursing Students

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Abstract

The focus of this article is on the multifaceted phenomenon of occupational segregation by gender in the healthcare sector. This qualitative study aims to investigate how individual factors, such as educational and professional choices, ambitions, expectations about the future, and motivations may contribute to occupational segregation by gender in the healthcare sector. The semi-structured interviews involved 40 people among medical residents and nursing students living in Italy. The results showed that individual, cultural, and organizational factors intertwine influencing career decisions and trajectories. The interviewees identified different key people when deciding on the specialisation or university course and during their educational path. Furthermore, in both nursing and medicine, female interviewees experienced episodes of discrimination, sexist comments, and comments on physical appearance. Finally, in light of the changes occurring in both fields, the article reflects on the devaluation of women's work and the importance of removing the stigma of men in female-dominated jobs.

Keywords: occupational segregation, gender, healthcare, gender inequalities, professional path.

1. Introduction

Occupational segregation by gender can originate from various political, economic, social, and cultural influences (Preston 1999; Reskin et al. 1986). The concentration of women at the bottom of the occupational hierarchy indicates the vertical component of occupational segregation. On

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the contrary, the horizontal dimension of the phenomenon is visible when women and men work in different sectors or occupations. For instance, professions such as teachers or social workers are characterised by a greater female presence (Rosti 2006). Gender pay gaps, the obstacles that prevent women from reaching higher positions ("glass ceilings"), and the high presence of men in leadership roles and management may be bolstered by gender stereotypes about some professions. Male-dominated jobs tend to be better retributed in comparison with female-dominated professions, often related to caring and socially undervalued (Dwyer 2013; Eurofound and European Commission Joint Research Centre 2021). Moreover, the literature on occupational segregation by gender investigates the different factors that separate women and men in their professional paths. The abilities, experiences, and preferences of female and male workers are addressed by scholars to explain these professional differences, together with hirers' preferences for one gender (Reskin and Bielby 2005).

Furthermore, role models, friends, relatives, and peer groups play an important role in shaping individuals' decisions about their careers and the way they perform and are determined to continue their professional or educational pathway, as resulted in a meta-study about professional socialisation in nursing by Price (2009). Professional socialisation seems to incentivise the reproduction of occupational segregation by gender, as students and young workers are expected to adapt to the environment and learn the values connected to the profession (Seron et al. 2016). In the healthcare sector, role models particularly influence would-be nurses and doctors. As the World Health Organization (2019) report highlights, women may suffer from the absence of female role models, especially in a male-dominated specialisation, such as surgery. In addition, nursing students and novices seek to imbibe the professional culture by observing others to assimilate all the aspects of being a nurse (Price 2009). Moreover, the literature on hidden curriculum detected the importance of practice-role models. In the nursing field, this kind of invisible education provided by experienced nurses seems to support the formation of a professional identity. According to Hunter and Cook's qualitative study (2018), new graduate nurses can distinguish between negative and positive conduct and stop assimilating when practices contrast their values. Nevertheless, they realised that may be necessary to "compromise professional values" while facing organisational problems (Hunter and Cook 2018, 3167). The hidden curriculum concept is also interesting, as it may clarify how inequalities, stereotypes, norms, and prejudice are conveyed to maintain the status quo (Amico 2018; Cinque 2016). As suggested by Bourdieu and Passeron (1987), the education system contributes to reproducing the established order and the structure of power relations within society.

Organizational factors and working conditions are associated with occupational segregation by gender, as discrimination, gender bias at work, and working schedules that make it difficult to conciliate work and family life can hinder women's careers (World Health Organization 2019). In

addition, occupational segregation by gender can be influenced over time by institutional measures (World Health Organization 2019). Political transformations can involve the labour market and, consequently, women's work participation. Gauchat, Kelly, and Wallace (2012) found that globalization, despite its variables that may interact to different extents with gender equality, is not yet able to defy occupational segregation and the gender earnings gap. All the factors mentioned above originate from certain cultural beliefs about gender. For example, Green and Cassell (1996), reviewing the approaches to women in management, describe the gender-centered viewpoint, according to which the low presence of women in leading positions is due to "feminine" characteristics that do not fit the aggressive image of the Western manager. Underlying the plight of women in the workforce cultural factors can be found, such as the idea of women as primary caregivers, the belief that depicts men and women as naturally different, and the traditional perspective on the relationship between men and women (Reskin et al.1986).

In the healthcare sector, occupational segregation by gender is interesting to investigate, as globally, women represent 70% of health workers, and 25% of them are in leadership positions, according to the World Health Organization (2019). Women work mainly in less retributed and lower social status positions. They are concentrated in nursing, midwifery, and primary care or specific medical fields (paediatrics, obstetrics, gynaecology, oncology, and dermatology) (ibidem). In the EU Member States, the increase in the demand for services has brought the widening of female-dominated sectors such as education, health, and care, encouraging women's employment (Eurofound and European Commission Joint Research Centre 2021; Wren 2013). In Italy, the physicians employed by the National Health System with less than 45 years were 63.8% women in 2020, but this percentage decreased to 43.9% among physicians with 45 years or older (Ministero della Salute 2022). Moreover, in 2020, among the staff hired with a permanent contract by the National Health Service, 49.9% of physicians and 77.7% of nurses were women (ibidem). According to the World Health Organization report (2019), discrimination on the grounds of gender in the workplace and gender stereotypes can incentivise occupational segregation by determining if one occupation or position is more masculinised or feminised. For instance, before choosing a medical speciality, the subject may reflect on family, domestic, and care responsibilities (Ku 2011). Moreover, the absence of mentors, episodes of discrimination, sexual harassment, and prejudices can impede entrance into some sectors. Different values and ambitions absorbed through socialization by men and women may early influence their careers and speciality choices (ibidem). Working in a feminine working environment requires efforts for men to maintain their identity. In a study conducted by Cross and Bagilhole (2002), men in female-dominated occupations seek to preserve their masculinity by developing alternative identities and distinguishing themselves from their female colleagues. Male nurses tend to prefer less "feminine" activities and specialities to overcome the stigma (Snyder and Green 2008). The

hierarchy between nurses and physicians retraced the Victorian familiar relationships, as medicine was a male-dominated profession and nursing was the classic example of a feminine occupation (Gamarnikow 1978; Porter 1992). Through laboratory experience, Braida et al. (2023) observed that nursing students were inclined to "neutralise gender". Yet, as Lupton's study (2000,45) revealed, men working in female-prevalent contexts go through challenges to their masculinity, including lesser possibilities to affirm or strengthen the masculine identity and the risk of being feminised and of being considered "effeminate or homosexual". In this sense, men attempt to confront these threats by reconstructing their profession to render it less feminine or their masculinity to fit the "female" workplace (Lupton 2000, 38). Christensen et al.'s study (2018) showed that male students in nursing programmes considered this profession stable and varied but they perceived to be shamed by ex-work colleagues because of their career choice. The topic of men in female-dominated professions was also addressed by Brown (2009), who noted a tendency in the literature about the male presence in the nursing sector to concentrate on the frailty of men in this context, overlooking material disparities and social powers.

To understand how men seek to re-store their masculine identity in female-dominated environments or jobs that are becoming more "feminine", the concepts of homosociality and compensatory manhood acts could be useful in this study. Firstly, homosociality means the "preference for the company of the same sex" (Lipman-Blumen 1976, 16). Homosocial heterosexual relationships are particularly important, as they maintain a certain ideal of hegemonic masculinity (S. R. Bird 1996). Borrowing the term "hegemony" from Gramsci, Connell (1987) described hegemonic masculinity as a form of being a man that is built through the dominance of women and the interactions with subordinated masculinities, such as homosexuals. This form of masculinity is subject to changes in time and place and can always be challenged and substituted with a new strategy (Connell, 2005) In addition to heterosexuality, the characteristics of hegemonic masculinity can be detected among certain fictional characters or movie actors (Connell 1987; 2005). However, those who possess power and richness might not adhere to this ideal of masculinity privately (Connell 2005). At the same time, hegemony needs a "correspondence between cultural ideal and institutional power, collective if not individual" (ibidem,77). As Connell (2005) explained, this is the reason why a corporate form of masculinity exists, suggesting that hegemonic masculinity is characterised by the "claim to authority" more than the exercise of violence. According to the relationship with hegemonic masculinity, complicit, subordinated and marginalised masculinities are also recognised (ibidem). Another concept to address in this study concerns the compensatory manhood acts, which are intended as processes of masculinity signification that derive from the impossibility of enacting hegemonic masculinity (Ezzell 2012; Schrock and Schwalbe 2009). In the therapeutic community studied by Ezzell (2012), aggressivity and subordination toward women and non-conventional masculinities

were used by men to signify their manhood. These acts are formed through interactions and may promote misogyny and homophobia, exacerbating inequalities (ibidem). In this sense, the "doing gender" proposal from West and Zimmerman (1987, 126) offers a different perspective, assuming that gender is constructed every day through interactions as "a routine, methodical and recurring accomplishment".

2. Methodology

The study aims to describe how individual factors (educational and professional choices, ambitions, motivations, and expectations) can contribute to occupational segregation by gender in the healthcare sector. The interaction of these factors with organizational and cultural drivers is considered in the research. For instance, gender stereotypes and prejudices can impact educational and professional decisions and possibilities, as well as working conditions. In particular, the research is focused on medicine and nursing, historically considered "male" and "female" fields. Moreover, tackling occupational segregation in the healthcare sector would reduce the risk of shortages or surpluses of employees, gender stereotypes, and stigma related to men working in "women's jobs". Enhanced gender equality in the sector could result in improved working conditions and more robust healthcare systems (World Health Organization 2019). The chosen population was composed mainly of medical residents and nursing students (those who are completing or have recently completed a bachelor's or master's degree). The hypothesis is that the healthcare sector is experiencing processes of de-segregation and that changes toward greater gender equality in the field are taking place.

The Grounded Theory seemed to be the most appropriate methodology to investigate the individual factors that drive nursing students and medical residents to choose a career path. In particular, the adoption of comparative methods, and the concurrent data collection and analysis facilitate new theorizations (Charmaz 2014; Glaser and Strauss 1999). Theoretical sampling involved 40 cases, 20 interviewees were students (9 female and 11 male students), while the remaining 20 were residents (10 female and 10 male residents). The cases came from three different Italian areas (Northern, Central, and Southern Italy) to grasp the potential diversity of context and experiences. The snowball sampling was adopted. An initial cluster of individuals was identified, and then, through the referrals from the interviewees, the sample became progressively bigger (Corbetta 2003). This sampling technique allowed participants to be easily recruited and resulted in none of the people contacted refusing the interview. When the process slowed down due to the geographic distance and the impossibility of reaching individuals from

other areas, some interviewees were identified through social media posts or messages in Telegram groups attended by nursing students and residents from all over Italy. Indeed, when possible, the interviewees were asked to provide one or more referrals of nursing students and medical residents from different geographical locations. Speaking about the possible limitations in the representativeness of the sample, the qualitative approach does not aim to obtain a statistically representative sample and to the generalizability of the results, consenting to focus on the comprehension of specific cases (Corbetta 2003).

The average age for the students is 25, and for the residents is 26,75. Even if nursing students started university earlier in their educational path, many of them decided to begin their academic careers later for several reasons. Residents are older since they can enter the medical residency after a six-year university course in medicine and surgery. Furthermore, the residents interviewed were obtaining different medical specialities (paediatrics, radiology, gynaecology, nephrology, anaesthetics, surgery, rheumatology, urology, orthopaedics, gastroenterology, and internal medicine). The choice to interview residents from different specialisations is motivated by the intention to detect any changes occurring within the medical sector. Most of the semi-structured interviews were conducted online due to the difficulties of reaching subjects (especially those who were working as residents or trainees in healthcare facilities) after the COVID-19 pandemic peak. The health crisis has marked a change in the manner online interviewing is perceived in qualitative studies. Online research was not seen as preferable to traditional face-to-face interviewing (Thunberg and Arnell 2022; Żadkowska et al. 2022) However, the literature identified the pros and cons of digital interviews. Among the advantages, the cost and time effectiveness and the reduction of emotional work at the expense of the researcher (Thunberg and Arnell 2022; Żadkowska et al. 2022) should be contemplated. Open, focused, and theoretical coding was conducted on the full transcript of the interviews. Two core categories emerged from the interviews: the moment of the choice and gender-based discrimination and stereotypes. These results can clarify how individual factors contribute to occupational segregation by gender and how professional decisions are made. Under the category "the moment of the choice" fall the dynamics behind which students and residents decide on their university course or medical specialisation. The second category encompasses the many episodes of sexism, discrimination on a gender basis, comments on physical appearance, and stereotypes experienced by female students and residents in the workplace and, to a lesser extent, at the university. In the discussion, another core category -emerged at a later stage and involving the changes in gender parity that are occurring in the healthcare sector- will be addressed.

3. Results

The main findings show that while choosing and during the educational path a variety of key people and role models seem to influence their motivations and ambitions. Moreover, the recurrent episodes of discrimination and sexual comments experienced by female interviewees depict environments that may affect women's working conditions. The following paragraphs will address the two core categories identified from the results in the medical and nursing contexts, respectively.

3.1. The choice: Professional socialization and key people

One core category that emerged from the interviews is the moment to choose the university course for the students or the medical specialisation for the residents. The respondents identify various key people that may have influenced or guided their choices to different extents. Despite the general lack of mentors, more experienced healthcare workers resulted as important models to boost their motivation. In addition, parents and relatives play different roles for residents and nursing students.

3.1.1. The choice of specialisation in the medical sector

Discussing the importance of key people and role models in the educational path, the results of this research show a general lack of mentors during the university years or the residency. In the medical field, female and male interviewees seldom identify a figure that could be considered a mentor among professors and senior doctors.

> *"[...]there is one of my bosses, a permanent physician who is a very, very good doctor. [...] She is a figure, let's say, in my opinion, important in what she does because she has a range of attention and also commitments, which go beyond what is the mere commitment, the mere working hours. I mean, it is not mere diagnosis therapy. She really goes deep, takes charge on a very personal level of the patient." (male paediatrics resident, 002)*

> *"Well, my mentor for my master's degree, yes, I think he was my thesis supervisor. He was really a great example for me. And it was also, I mean, it was because of him that I then decided to take this path. [...] I have great esteem and respect towards him and I am very happy with the path I took with him, so I consider him at least for that phase of my life, my mentor." (female nephrology resident, 003)*

However, many interviewees tend to consider their thesis supervisor and co-supervisor as key people during the academic years or at the moment of choosing the speciality. Hypothetically, students strive to liaise with professors and the writing of the thesis may constitute a crucial occasion to get in touch with the teaching staff. Furthermore, residents consider positive role models some of the male and female senior physicians or more experienced residents they encountered during the internships or the residency.

> *"My thesis supervisor who was very, very welcoming and I had a lot, a lot of enthusiasm in everything he did. He was also very human in talking to ... With the patient, with the patient's parents." (female paediatrics resident, 004)*

Compared with female residents, men tend more to point to their fellow residents, friends, and peer groups as key figures when choosing a specialisation or throughout their whole training path. Male residents seem to assign more importance to the confrontation with friends and peers and their advice.

> *"Honestly, there was a colleague of mine who was like, 'Oh yeah, that might be okay,' let's say, yeah, I talked a little bit about it with my group that I was studying with and they kind of, they saw me quite a bit as a ... as a possible radiologist." (male radiology resident, 014)*

> *"My friends [...] made me grow a lot, even professionally, in my opinion, as well as a student than as a friend. But they were decisive because we were ... we were all, in short, interested in a clinical subject." (male internal medicine resident, 015)*

Generally, the friends are described as “happy” and “proud” of their speciality choices. Nonetheless, two male urology residents state that they have been mocked at or received rude comments for their choice of specialisation. One respondent considered the friends' comments to be joking and said he was not bothered by them. Speaking about the role of the family, most of the interviewees declare to have chosen the speciality without any conditioning from their parents, who are described as “glad” for the professional decision of their child. However, some female residents revealed that the relatives, especially the fathers, were concerned about their daughters’ future quality of life. One female resident affirmed that her relatives were relieved when she announced the choice of a less demanding speciality. This apprehension may hide a certain idea of women's caring role and “feminine” work.

"Especially when, precisely, I told them that I didn't want to be a surgeon anymore, that I wanted to do something a little quieter. Well, they were happy, yes, yes." (female gastroenterology resident, 012)

3.1.2. The choice of the nursing school

In the case of nursing students, female and male interviewees identified various key people for their educational choices. Although some of them (both male and female) declare to have made the decision autonomously and without any conditioning, most of the students can indicate those who helped them to choose. Relatives, friends, and acquaintances who work in the healthcare sector or have experienced long periods of hospitalisation seem to have influenced the interviewees. Compared to residents, nursing students did not meet academic staff before deciding their educational and professional future. Therefore, friends and parents appear to be particularly significant figures, especially considering the young age of most students. Only one student believes that his high school professor inspired him to choose a health profession.

"Yes, I always thanked my high school anatomy professor, he always gave me this imprint...he would have preferred the medical part a little bit more, however, in the end, he always pushed me into the health field, and indeed even after graduation, […], I thanked him, I sent him a message, he still remembered me, so that's important. Let's say he was fundamental in this choice." (male recently graduated in nursing, 032)

"My father, my mother, my sister, my friends were the first ones on this and they told me, 'Go home and go, do what you like, because if you really didn't want to do nursing, you wouldn't be so bad now.'" (female third-year nursing student, 027)

Among the various kinds of key people identified, mothers emerged as particularly crucial figures for both female and male respondents. Mothers' advice and experiences seem to guide their choice to pursue nursing school, along with the opinions of family members working in the field. In the latter case, the direct experience of family members allows respondents to learn about the profession beforehand, to acquire a kind of anticipatory socialisation.

"Then also talking about it at home, with mom, anyway, a piece of advice from a parent is needed, I think she is the person who knows you best. With her, I said, 'I want to do this.' She says, 'I could see you doing this.' And so, already, I had this support in the family, which I repeat anyway, it's needed." (female third-year nursing student, 022)

> *"Yes, my mother, my sister, my sister, because she became a nurse and so she made it so ... she made this desire grow in me and my mother because she has always been, precisely, as already mentioned, imprinted on to these subjects, she has always appreciated these ... these medical subjects." (male second-year nursing student, 037)*

The traineeship is a crucial experience to confirm the choice to become a nurse. Many interviewees stated that the traineeship provided by the university in the first months of the graduate program motivated them to continue. The practical part of education may motivate the students by showing the daily work of nurses and applying the knowledge gained from books. Moreover, during the internships, students can get in touch with the patients and learn how to deal with them.

> *"It was a surprise the whole theoretical world, behind it, the training. Then with the internship it was love, it was a beautiful experience on a personal level, on a work level. I felt it was the right thing." (female third-year nursing student, 024)*

The interviewees often describe the nurses' and tutors' different attitudes during the internship. Positive role models are portrayed as young, motivated, capable, and willing to teach. These figures can convey their passion to the students and may help them to develop a professional identity. On the contrary, the respondents declared to have observed nurses with low motivation, unprofessional behaviours, and who are not inclined to teach. In addition to experienced nurses, physicians participate in the students' professional socialisation and education. Through the respondents' lenses, physicians may be helpful or have a "detached" relationship with the students. According to some interviewees, this distance is motivated by the hierarchy and the power relation between the medical and nursing staff.

> *"So, people perhaps more willing, so, doctors more willing to involve you, just even in the activities, in helping them, and doctors, let's say, more detached […]" (female third-year nursing student, 025)*

The choice seems to vary according to the gender of the interviewee. Most male respondents reveal that they have tried to pass the medical school entrance test or to enter into other health disciplines schools before enrolling for the nursing test. Compared to their male colleagues, more female respondents affirm that they have chosen this degree program for a vocation or have initially thought about a humanities university course. When speaking about the profession, both male and female students indicate care work as a peculiar characteristic of being a nurse.

Expressions such as “help”, “empathy”, “caring for the patient”, “human sympathy”, “emotional support”, and “caring for the psychology of the patients” are often used. These attributes are described as opposed to the medical approach to the patient, more “detached” and “distant”. Through the words of the interviewees, this emphasis on care work as a crucial aspect of the profession may seem a reaction to the devaluation of nursing. This result contrasts with Snyder & Green’s (2008) findings about the male concentration in units like ICU and ER – which require more autonomy and physical strength- and the appeal that nursing would have among men if publicised as it was a technical job. Indeed, interviewees were asked to indicate the most prestigious units and which they preferred to work. Emergency, ICU, and ER departments were signalled as the most prestigious, and more men considered them as their favourite than women.

In some interviews, gender inequalities and stereotypes were indicated as factors that can contribute to the depreciation of nursing, traditionally a female-dominated field. According to some interviewees, the physician-nurse hierarchy and the implicit norm that “the physician orders and the nurse executes” are effective. The high workload, lower remuneration, and few opportunities for career advancement could be the effect of this devaluation in terms of social status.

> *"In the sense that not being on the other side, I couldn't really tell you why, however, it has always been seen that the nurse carries out the orders, so the doctor is the main figure, at the level of care, at the level of assistance, according to them." (male third-year nursing student, 032)*

3.2. Discrimination and stereotypes toward women in the healthcare sector

Discrimination episodes and sexist comments from male physicians, nurses, and patients seem frequent toward female nursing students and residents in both fields. The high presence of women in nursing does not prevent female nursing students from experiencing gender-based discrimination incidents. At the same time, women appear to struggle to be completely accepted in medicine, a traditionally male-dominated discipline that is progressively more “feminine”.

3.2.1. Women in medicine and gender-based discrimination

The interviews with female residents outline the condition of women in medicine. Women appear to be foreign and subordinate bodies, especially in traditional masculine environments, such as surgical specialities. The respondents’ histories suggest the daily recurrence of discrimination by male physicians and patients in the medical workplace. Sexism, comments on appearance, gender

stereotypes, and the devaluation of female physicians' work and abilities could be considered compensatory manhood acts (Ezzell 2012; Schrock and Schwalbe 2009) enacted to counterbalance the growing presence of women in a traditionally male field. The feminisation of the medical field, along with the other "male" professions in the healthcare sector (Adams 2010), could be perceived as a limitation to the idea of masculinity built in years of male prevalence over medicine.

Female interviewees observed episodes of discrimination, especially in hospital departments, during the traineeship and the residency work. Gender discrimination was reported in the university setting to a lesser extent, although the academic environment appears not entirely free of unequal treatment and sexist attitudes. Female interviewees complained that professors were stricter and more demanding of female students. By contrast, male residents declared that some professors (both male and female) may prefer female students during the exams. Overall, men report to a lesser extent that they have witnessed incidents of discrimination compared to their female counterparts. Some male respondents recognised that female colleagues may experience discrimination, sexist comments, and stereotypes, especially from patients.

> *"Yes, maybe with... with men, yes...there are some female colleagues who complain that maybe we residents are addressed, I don't know, the simple greeting, like even from the patient, they greet us, maybe saying: 'Hi doc', and they are told, 'Hi young lady', very often they complain about that, yes." (male internal medicine resident, 015)*

Women's work in medicine appears often devalued and their abilities questioned. Female respondents complained that they are frequently addressed as 'young lady', 'darling', and 'nurse', while their male colleagues are automatically called 'doctor'. Similarly to patients, male physicians are used to addressing female residents as "little doctors" or 'ladies'. Female respondents consider these epithets as a lack of recognition of their professionality.

> *"I am the young lady. My colleagues are 'the young lady', while the boys who are with me in the clinic will never be the young man, but they are always the doctor. It is taken for granted that they are the doctor. We don't always have the security of being called doctors." (female paediatrics resident, 001)*

Sexist comments and jokes about the appearance of female students and residents from physicians and professors are detected frequently. Many female interviewees revealed a daily routine of comments, innuendoes, and jokes from colleagues, using expressions like 'the same stories' and 'the habitual thing'. In particular, one female resident said to have heard a

complaint about women in medicine described as “too caught up in feelings”. Some of the female residents tended to justify this kind of attitude, suggesting that some conduct could be attributable to the character of the individual doctor or professor. Although female interviewees may feel insulted or bothered by the comments, the general reaction is not to answer or react. Hypothetically, the fear of not being protected, of encountering hostility from colleagues, and of showing themselves in a bad light may prevent female residents from replying to sexist behaviours. Moreover, according to residents’ stories, women in medicine are not considered capable of carrying out certain activities or being able to work in male-dominated fields, such as surgery or orthopaedics. Physical strength is mentioned as a limitation for women during specific surgical operations, even though today technologies have been developed to assist doctors' work in difficult procedures where physical endurance is required.

> *"Let's say orthopaedics is one of those environments where it's even more visible because the surgical environment, especially orthopaedics, where you hammer, saw, split. There is this idea that men, you know? And that women aren't physically strong enough blah, blah, blah, they're not…they don't have the practical sense that men have, so what can happen, is that maybe, especially in the operating room, they tend to trust a male more than a woman." (male orthopaedic resident, 018)*

At the root of these beliefs about women's abilities in medicine, a certain idea about men and women’s “nature” can be traced. Women physicians are not considered capable of carrying out certain tasks, especially those that are particularly male-gendered. At the same time, for other types of activities, some respondents maintain that women seem to be burdened with expectations and considered more reliable and responsible than men. Some of the residents also observed that colleagues complain when a female physician decides to take time off from work for family reasons. Pregnant physicians -who need to be relocated to less health-threatening or less demanding jobs- or women on maternity leave generate organisational problems due to the lack of resources.

> *"[...] at times, however, it has been noted that most women, precisely even older, therefore trained, are a step ahead. They reason in a way, sometimes indeed, better even than men, so it has in some ways sometimes been argued that women are smart and can do this job well anyway [...]." (female anaesthesia resident, 005)*

Professional socialisation can be an obstacle course for women surgeons - especially mothers- as they face gender prejudice, life-work balance issues, and difficulties in reaching top positions (Oliveira dos Santos et al. 2021). Female and male interviewees described surgery and

orthopaedics as male specialities. The reasons lie in low quality of life, long work hours, difficult work-life balance, competitive environment, and the devaluation of women's work. Some interviewees reveal that women are often addressed informally, ignored at the operating table and downgraded. Moreover, after the pregnancy, surgeons struggle to enter the operating room since they missed months of training. Family responsibilities and parental leave may widen the training gap.

> *"I have heard...I have heard outside [...], however of people quitting surgeries, especially women, because maybe even in the choice of the first… of the second operator, of the first operator they always came after male colleagues [...]." (male internal medicine resident, 017)*

In other traditionally male-dominated specialisations, such as urology and orthopaedics, some male residents have witnessed episodes of goliardery and locker-room talks. They report heavy jokes in the operating room, comments about the male residents' physical size, or homophobic epithets. The situation may change in female-dominated specialisations. Paediatrics is perceived as a more women-friendly environment, as physicians' motherhood and pregnancy seem better accepted among colleagues. However, one of the male residents claimed to disagree with the belief that paediatrics is an extension of the maternal instinct. On the other hand, gynaecology appears as a peculiar female-dominated specialisation, as it maintains the status and prestige of surgical disciplines. This specialisation ensures career opportunities and earning possibilities despite the women's struggle to reconcile life and work time due to on-call availability.

> *"Gynaecology, on the other hand, despite what it may look like on the outside, is a masculine environment, but because, let's say, that requires almost 24-hour availability, because they can call you for delivery at any time of the day or night." (male internal medicine resident, 016)*

3.2.2. "He certainly is better at it, you can see it in his face": Discrimination toward women in nursing

Despite the historical feminine context, nursing is not immune from gender-based discrimination and sexist comments. The nursing and medical staff seem to prefer male students, as they are considered more skilled, competent, and less emotional. In addition, female students are exposed to sexist comments during their traineeship from male nurses, physicians, and patients. The comments seem particularly directed at the physical appearance of female students. Interestingly, one male student recognised that the figure of the female nurse is "sensualised and

sexualised". As happens for the residents, female nursing students complained about being called 'ladies' or 'babies'. Also in nursing women's professionality struggles to be recognised and evaluated. Nonetheless, fewer episodes of discrimination were reported in the university context (during exams or lessons). In the case of nursing, compensatory manhood acts (Ezzell, 2012; Schrock and Schwalbe, 2009) may constitute a strategy aimed to re-establish masculinity. Manhood is undermined by the stigma of being a male nurse working in a female-dominated sector. The hierarchy between nurses (generally women) and physicians (traditionally men) may exacerbate this stigma and the perception of being unable to exercise masculinity.

> *"However, in my opinion, this thing that more emphasis was being put on physical appearance, to tell you, rather than how talented you are. Maybe they would say, 'How pretty you are,' rather than: 'How talented you are.' It came first how you look, rather than how you actually are, and what you do."*
> *(female third-year nursing student, 026)*

> *"[…] every time you arrive at a new place, one of the first comments that are made by the coordinator, the female coordinator, when I arrived, was always, 'Good thing you're a man,' because being a man in this job paves the way for you in a way that I didn't think was possible. [...] you already have authority by the simple fact that you are a man." (male master's nursing student, 031)*

Despite the expected stigma against men in nursing, male students observed or experienced gender-based discrimination incidents to a lesser extent if compared to female students. Some interviewees noticed that female students were preferred in university, similar to what was found among residents. Some also complained that men usually are not chosen in gynaecology and paediatrics for the internship due to the reluctance of patients to be visited by male nursing staff. In short, male trainees would end up not practising and learning the profession in these units. Nevertheless, one male student admitted that nurses particularly appreciate their work compared to their female colleagues. This difference in evaluating students derives from gender stereotypes, according to which men are less prone to carry out care work. Women's ability to perform caring tasks is taken for granted, as it is inherent in their "nature." In contrast, men's care work is highly valued.

4. Discussion

The many factors that can contribute to the phenomenon of occupational segregation by gender may intertwine. The study of individual factors brought to light the cultural (stereotypes, prejudice, and gender practices) and organizational aspects of the problem. The results concerning both female and male residents showed difficulties in finding a mentor or a role model due to the detached relationship between professors and students during the university years. The main key person they indicate is the thesis supervisor or co-supervisor, as thesis writing allows the student to get in touch with at least one academic staff member. These figures seem to play a crucial role during the academic course and when choosing the specialisation. Unlike women, many male residents tend to consider their friends and peer groups as fundamental during the whole academic path and at the time of choosing the specialisation. Homosociality can help understand the importance male residents place on the company of peers. This concept describes the non-erotic interest of same-sex people that can separate men and women, hegemonic and non-hegemonic masculinities through segregation in the social space (S. R. Bird 1996, 121; Lipman-Blumen 1976). Homosocial relationships allow preserving those norms and identities that are appropriate to hegemonic ideals to the detriment of women and other masculinities (S. R. Bird 1996). Homosociality may also explain the homophobic comments and appellations between residents, the locker-room talks, and goliardery. Paradoxically, in nursing, the preference for men comes from female nurses who look favourably on the arrival of new male interns. Women in female-dominated fields may believe that the entry of men could improve the social status and, consequently, the value assigned to the profession (Hedlin and Åberg 2020; Hultin 2003). This belief can explain the preference of nurses for male students detected during the interviews. However, female nurses seem not to benefit from the male newcomers, as their arrival produces increasing levels of vertical segregation due to the increasing presence of male managers (Porter 1992). Furthermore, some factors may weaken women's solidarity among female workers- such as gender stereotypes, the overlooking of gender-based inequality in the workplace and the focus on individual choices, and the depreciation of networking among women- as arose from the analysis of the literature by Webber and Giuffre (2019).

Observing the role of parents and relatives in influencing educational choices, the study underlined some differences between residents and nursing students. Some female residents reported their relatives' concern about the future quality of life as physicians in some demanding specialisations, suggesting a stereotypical ideal of women in terms of their caring role in the family. On the other hand, both male and female nursing students recurrently indicated their

mothers as key people or even gatekeepers in case they were already professional nurses. Moreover, for nursing students, the traineeship during the university course and the presence of role models can incentivise interest in the profession. Motivated and skilled nurses or physicians represent an example during the development of students' professional identity, regardless of gender. Nursing students also found a strategy to tackle the devaluation of the profession and the nurses-physician hierarchy. The exaltation of the care work and the relationship with patients seems to motivate students despite the lack of recognition of the profession and often difficult working conditions. However, the interviews revealed that the devaluation of nursing goes beyond the workplace and can be perceived through the words of relatives and friends. Two opposing forces may influence the decision to pursue a career in nursing. The possibility of finding stable employment after a short period of training (three years) and the stigma attached to a profession considered feminine and disqualifying.

In both fields, female respondents experienced episodes of discrimination, sexist comments, and comments on their physical appearance. Even in a female-dominated occupation, women in nursing face prejudice, bias, and gender stereotypes. In medicine, women's situation appears more complex, as a higher female presence is relatively recent. Over the 1970s, women started to study traditional male occupations, such as law and medicine (Reskin et al. 1986). Discriminatory workplaces during traineeship and residency may affect the choice of specialisation before or after enrolment in a speciality school. As Barnes et al. (2019) showed, gender bias – experienced by female trainees in surgery – may produce an intention to drop medicine, affecting women's careers. Furthermore, female respondents seem aware of the difficulties in balancing family and work, especially in some specialities. Often, women on maternity leave experience discrimination, as they constitute an organisational problem due to a lack of resources. As the World Health Organization (2019) points out, women are often required to enter into healthcare organizations conceived for male lifestyles.

In conclusion, an additional category emerged from the interviews. Unequal treatment and sexist comments may be enacted to maintain a certain ideal of hegemonic masculinity in fields that are feminised or are becoming more feminine. As Connell and Messerschmidt (2005) noted, the literature on organisations demonstrates that hegemonic masculinity can play a crucial role in the workplace. The results show that in the healthcare sector, nurses, physicians, and even patients seem to compensate for their masculinity (Ezzell 2012; Schrock and Schwalbe 2009) in female-dominated environments or contexts where the female presence is increasing. Similar to what was detected by Barnes et al. (2019) in the case of female surgical trainees, according to which microaggressions come mostly from patients, doctors in leadership positions, and nurses.

The interviewers suggest that positive changes are occurring over time due to the improvements in the gender balance and the growing awareness of discrimination among young

professionals. The interviewees perceive a greater gender balance in medicine and, more specifically, some changes in traditionally male-dominated specialities. Some female residents hope that the increasing number of women in medicine will improve working conditions and promote a women-friendly environment. A recurrent theme in the interviews is the inevitability of the improvements, as the field will have to adapt to the increased presence of women and get used to working with a growing number of women. In nursing, many interviewees detect some changes in the content of the work and the growing number of men in the profession. Nurses seem to have more responsibilities and more competencies are required than in the past. According to one of the respondents, the growing dynamism in the critical care units is attracting men to nursing. In addition, the physician-nurse hierarchy seems to be less evident among young staff members. Despite incidents of gender discrimination and sometimes difficult working conditions, interviewees show optimism for future improvements in light of the growing gender balance. Lastly, some reflections about the limitations of this study should be addressed, as it is restricted to differences between two genders, assuming a binary lens and without considering race and ethnicity. Indeed, intersectionality (Crenshaw 1991) may have consented to give a deeper look into the working conditions of people of racialised or different sexual orientations and gender identities. Dill & Duffy (2022), in this sense, evidenced how black women experience the intertwining of sexism and racism in the care sector, as their presence is particularly high in low-remunerated professions.

5. Conclusions

From the responses of the 40 interviews educational and, consequently, professional choices may derive from a variety of considerations about the future, experiences along the path, ambitions, and advice from key people. Individual, organizational, cultural, and even political factors (as in the case of a decision made to increase employability or the possibility of obtaining a permanent job) may influence occupational segregation by gender in the healthcare sector. Furthermore, the value of care work emerged as one central theme of the study. During the COVID-19 pandemic, a reflection on caregiving and its devaluation arose. The high presence of women in care-related work has been highlighted, suggesting the increase in the value of care work as a possible solution to the gender pay gap (Thomason and Macias-Alonso 2020). The findings gave an idea of the depreciation of the nursing job and the attempt of male nurses to compensate for their manhood. On the other hand, most nursing students focused on the importance of care, intended as an empathic relationship with patients. This duality allows male nurses to overcome

the stigma of being a man in a feminine job. Instead, the entry of women into medicine is changing the way caregiving is intended, and a more empathic approach to patients may be adopted in the future (Riska 2001). Increasing the value of care work could represent a measure to diminish occupational segregation by gender in the healthcare sector, acknowledge the so-called "women's jobs", and remove the stigma on male caregivers. In conclusion, this study may highlight the necessity to deepen the implications of occupational segregation in the healthcare sector, to raise awareness about the phenomenon, and provide training to avoid discrimination episodes.

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