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Numbers Do Not Tell the Whole Story: Gender and Medicine in Portugal

Maria Helena Santos, Instituto Universitário de Lisboa (ISCTE-IUL), Cis-IUL, Lisbon, Portugal and Centre en Etudes Genre LIEGE, Université de Lausanne, Lausanne, Switzerland.

Lígia Amâncio, Instituto Universitário de Lisboa (ISCTE-IUL), Cis-IUL, Lisbon, Portugal.

Patricia Roux, Lausanne University, Lausanne, Switzerland.

Abstract

Despite a progressive increase in the number of women in medicine, gender inequalities remain. This article presents a study analyzing the gender dynamics of tokenism in the medical field in Portugal, through the experiences of male specialists in female areas and female specialists in male areas and through their strategies for coping with such situations. We conducted individual, semi-structured interviews with nine female doctors and eight male doctors aged between 32 and 62 years old. Results show the links between tokenism dynamics and gender asymmetry in medicine, putting female tokens at a disadvantage in relation to male tokens. Token positions occasionally produce gender arrangements but, all things considered, do not transform female and male positions either in the medical field or in the private sphere. We conclude that tokenism contributes to maintaining the gender social order.

Keywords: medicine, gender inequalities, tokenism, dis/advantages

Introduction

The persistence of gender segregation in the western labor market constitutes a crucial problem despite the progress registered recently (Hultin, 2003). Medicine represents one case where progress has been seen (Boulis, 2004; Boulis & Jacobs, 2008; Crompton & Lyonette, 2011; Lapeyre & Le Feuvre 2005; Linehan, Sweeney, Boylan, Meghen, & O' Flynn, 2013; Miller & Clark, 2008; Rosende, 2008; Riska, 1993) and Portugal proves no exception (Machado, 2003; Marques, 2011). In the last two decades, the number of women in medicine rose nationally by twelve percentage points, up from 11,385 female doctors (40%), out of a total of 28,326 in 1991 to 23,637 (52%) out of 45,289 in 2013 (PORDATA, 2014).

Although the gender-gap has narrowed in the medical field (Rosenthal, Levy, London, Lobel, & Bazile, 2013), a pattern of horizontal and vertical gender segregation tends to prevail (Miller & Clark, 2008; Riska, 2011; Rosende, 2002), with persisting and substantial asymmetries between men and women. Research conducted in several countries (e.g., Lapeyre & Le Feuvre 2005; Linehan et al., 2013; Rosende, 2008; Rosenthal et al., 2013) shows that women continue to experience substantial disadvantages in comparison to men, and to work more in part time, while men occupy the higher status positions and are better paid (Lo Sasso, Richards, Chou, & Gerber, 2011), even in what might be deemed female specializations such as pediatrics (Machado, 2003). Moreover, the reconfiguration of segregation extends to countries with more balanced gender distributions in the medical field such as Russia, Finland, Britain and Sweden (Rosende, 2008).

In Portugal, this gender segregation is reflected in data from the Portuguese Medical Association in 2009: women are over-represented in specialties such as psychiatry for children and teenagers (74%), anesthesiology (66%), pediatrics (63%) and gynecology (58%) and under-represented in urology (1%), orthopedics (7%), sports medicine (8%) and in surgery, from cardio-thoracic surgery (8%) to general surgery (21%). Our study focuses on

some of these fields, particularly on the experiences of female and male doctors who work in an area where they are a small minority, to see in which way their respective token positions differ in the gender hierarchy.

Rosabeth M. Kanter (1977, 1993) proposed one of the earliest answers to the workplace gender segregation problem. She defines individuals who experience contexts where their sex represents a low level numerical minority (i.e., in "skewed groups" they constitute less than 15% of the entire group) as "tokens", usually hired to serve as representatives of their category, as "symbols" and not as individuals. She defines the majority as "dominants". From her research, Kanter reaches the conclusion that the proportional rarity of tokens is associated with three "perceptual tendencies" (Kanter, 1993, p. 210): a higher token visibility, which results in performance pressures; a contrast or polarization of the differences between tokens and dominants (e.g., in terms of sex), which may lead to the former's isolation or social exclusion; and the group assimilation of stereotypical roles, resulting in a sort of "role entrapment", which makes tokens feel stuck and unable to fully express themselves.

Various research projects have more recently explored sex distributions by group composition and confirmed in the case of female tokens the three perceptual tendencies identified by Kanter (e.g., Maccorquadale & Jensen, 1993; Yoder Adams, & Prince, 1983). Research taking gender into consideration have led to the criticism of Kanter's perspective (e.g., Budig, 2002; Floge & Merril, 1986; Heikes 1991; Williams, 1995a; Yoder, 1991, Zimmer, 1988), arguing that solely numeric based analysis, "without taking into consideration the broader societal context in which these work groups operate" (Yoder, 2002, p. 3), will always be an insufficient perspective on such situations. In line with Laws (1975), they conclude that tokens only suffer this marginalization in cases where there is a double deviance, thus, when the tokens are members of a proportionally under-represented group and

experience low social statuses, for example, in the case of women or social minorities (see Yoder & Berendsen, 2001). Thus, working in a professional field of the other gender, men start out from a better position than women (Yoder, 2002; Zimmer 1988), benefiting from greater gender advantages (Floge & Merril, 1986; Heikes, 1991; Ott, 1989; Williams, 1995a, 1995b). This has been showed by studies comparing, for instance, male nurses (e.g., Heikes, 1991; Williams, 1995a) to female doctors (Floge & Merril, 1986) or male to female police officers (Ott, 1989).

In addition, due to collective past experiences (of success in the case of men, and of failure in the case of women), male and female tokens react differently to the dynamics of tokenism, with men tending to interpret them as a challenge and women as a threat, as shown by Barreto Ellemers, and Palacios (2004) in Spain. Therefore, it seems that in the medical field the prevailing masculinity norms are not questioned by neither female nor male tokens.

The advantages that male tokens take out of their dominant position in the gender relations can be also perceptible in the way people interpret these males' place in a "women's work". For example, as they do not expect to see a man as a nurse, patients sometimes mistake male nurses for doctors (Floge & Merril, 1986). This behavior/reaction contributes to facilitating these nurses' rise to positions considered more "legitimate" for men (Williams, 1995a). It also reflects the corresponding assumption that men are more capable and qualified than their female counterparts: "masculinity is often associated with competence and mastery, in contrast to femininity, which is often associated with instrumental incompetence" (Williams, 1995a, pp. 106-107).

Another effect of gender relations in tokenism dynamics involves the way in which the majority receives the small minority into the profession. In traditionally female professions, men are better integrated (Heikes, 1991) as a result of women's attempts to increase their professional status through the participation of men (see also Floge & Merril,

1986, and Williams, 1995a). In traditionally male professions, this welcoming process seems to be not as positive because the entrance of women is perceived as a threat to the status of those professions (Ott, 1989). Consequently, men enhance their careers obtaining higher status positions and women are stranded in the low status positions and areas. This process, which occurs in several specialist medical fields (Riska, 1993), as for instance surgery (Riska, 2011), has been designated as "re-segregation" (Reskin & Roos, 1990, cited by Boulis, 2004).

The literature conveys how tokenism dynamics vary according to both the sex of the token and the nature of the gendered organization (see Acker, 1990). As the gender orders prevailing in a given society (Connell, 2002; Williams, 1995a) influence these dynamics, they reinforce asymmetries (i.e., gender regimes) in organizations. The health sector is a gendered organizational structure (Doyal, 2001; Riska, 1993), as international (e.g., Lapeyre & Le Feuvre, 2005; Linehan et al., 2013; Rosende, 2008; Williams, 1995a) and Portuguese research findings (e.g., Fernandes Perelman, & Mateus, 2010; Laranjeira, Marques, Soares, & Prazeres, 2008; Marques, 2011) have demonstrated in the cases of both nursing and the medical field in general. This health gendering may shape not only choices of specialty and other career opportunities, but also the relationship between health professionals and clinical practice (Fernandes et al., 2010)

Furthermore the symbolic asymmetry theory (e.g., Amâncio, 1997; Amâncio & Oliveira, 2006) allows us to think that in masculine professions such as medicine, the perception of men as distinctive individuals would be confounded with the model of professional, while women would be seen as an undifferentiated category based on sex, representing the other, thus contributing to maintain men's dominant position. An example of this confusion which is relevant for our study is the association of male stereotype with the competencies needed for the profession. We expect that female doctors (the other) have to make greater efforts to prove their competencies, as shown in a research in the medical field

in Brazil (Santos, 2009). Moreover, it is likely that female doctors experiencing token conditions tend to adopt coping strategies that facilitate individual adaptation, but contribute to maintain the gender asymmetry in the long term, as shown in previous studies. Such is the case of individual merit valorization and the denial of personal discrimination, a phenomenon identified by Crosby in 1984 and subsequently confirmed by several research projects carried out in Portugal, whether approaching females in positions of power (Nogueira, 2009), in politics (Santos, 2011), surgery (Marques, 2011) or engineering (Saavedra, Araújo, Oliveira, & Stephens, 2014). Women seem to make a distinction between themselves and their group, recognizing discrimination against women in general, but not against themselves as individuals (Roux, 2001).

Given the scarcity of empirical research on gender in the medical field in Portugal, apart from the studies by António Manuel Marques (2011) and by the Portuguese Directorate-General for Health (Laranjeira et al., 2008), our study aims to analyze experiences and strategies of doctors (male and female) in minority professional positions from a gender perspective, that is, developing an approach which examines the interconnection between tokenism and gender hierarchy. In keeping with Marques (2011), this study adopts the gender symbolic asymmetry model (Amâncio, 2007; Amâncio & Oliveira, 2006), according to which gender representations differentiate men as a symbolical reference from women as the other. We assume in this study that this gender asymmetry influences the tokenism dynamics, contributing to the advantages that men gain from token position when compared with women. The following research includes semi-structured interviews and contains testimonies from male doctors in specialties traditionally invested by women and from female doctors in specialties traditionally invested by men.

Participants and procedures

We carried out interviews with 17 white Portuguese doctors: nine female and eight male doctors working in six hospitals located in and around Lisbon. We chose medical specialties in which the participants hold token positions. Three female doctors are specialized in orthopedics, two in general surgery, two in sports medicine and two in urology. The majority are married (N = 5), three are single and living alone, one is divorced (living with two children). Among these married women, two have a single child, aged 26 years and 17 months old respectively, one has two children of less than ten years and one was pregnant at the time of the interview. We also interviewed two male doctors from each of the following specialties: anesthesiology, gynecology, pediatrics and psychiatry for children and teenagers. Four are married, four are divorced (three are living alone and one is cohabiting with a new partner) and all have 1-4 children. Most children are already adults and only two men have children under the age of ten.

As a result of the more recent entry of women in the medical profession (the males in our sample entered medicine between the 1960s and the 1990s and the females between the 1970s and the 2000s), men are older (M = 51.63, SD = 11.17) than women (M = 42.78, SD = 11.20): five females and two males are aged under 40, while four females and six males are older than 49.

The sample was selected according to the snowball technique that began with the personal contact of an employee at the Portuguese Directorate-General for Health. Participants first received details about the goals of the study by phone, along with guarantees of confidentiality and anonymity. The interviews took place in a quiet place (somewhere in the respective hospital, in a meeting room, office or in a quiet cafeteria), between the beginning of November 2013 and the middle of March 2014 and lasted between 30 minutes and 95 minutes. With participant consent, we recorded the interviews before transcribing them in full.

The interview script covered the issues discussed in the theoretical framework, that is: the experienced effects of tokenism and the strategies deployed to cope with this, explanations for gender dynamics and measures favoring equality and change as well as career trajectories and family-work balance.

Following an exploratory screening of the data using Alceste 2012 software,[1] we conducted a thematic analysis on the output obtained with the aim of "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). This thematic analysis allowed us to interpret and problematize the classes obtained with the software having as rational: the identification of the diversity within each major theme (identifying subthemes), while maintaining the distinction between themes. This positioning is influenced by the social constructionist perspective in gender studies (Nogueira, 2001; Marques, 2011) which understands texts and discourses as constructions of reality anchored in social, political, historical and cultural contexts (Gergen, 1973). As the gender division of labor plays a major role in career development from a gender perspective, we considered the following variables: sex (female vs. male), marital status (living in a couple vs. alone), parenting status (with children vs. without) and age (under 40 vs. over 49 years old).

Results

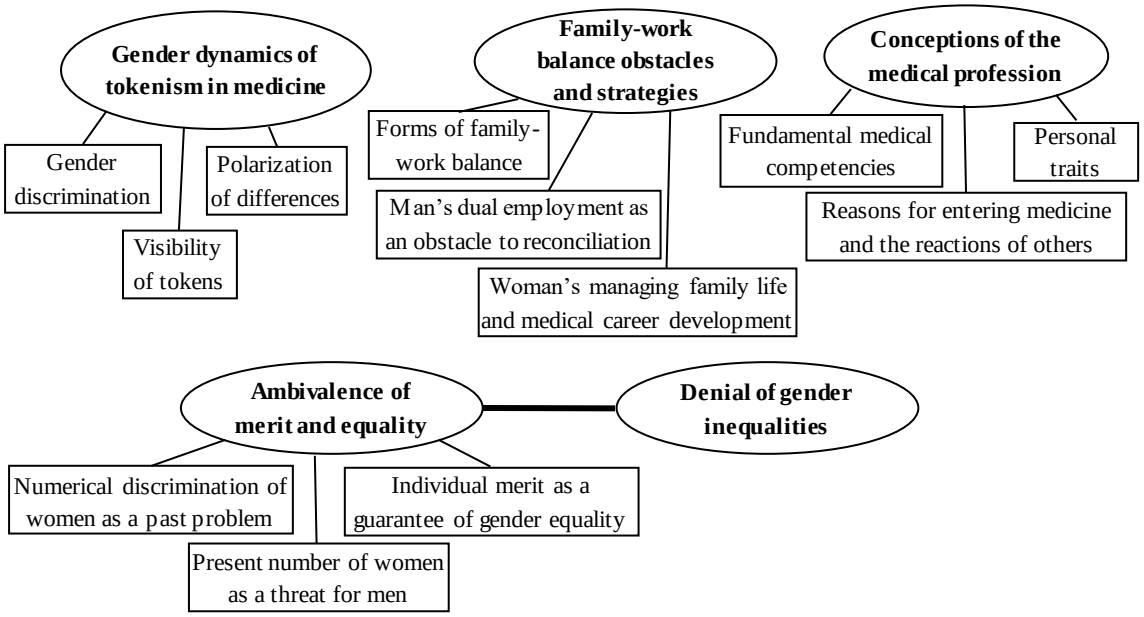
Five major themes were identified that we labeled as follows: i) gender dynamics of tokenism in medicine, ii) family-work balance obstacles and strategies, iii) conceptions of the

[1] Alceste is quantitative textual data analysis software that performs Analysis of Co-occurring Lexemes in a Set of Text Segments. To identify the internal organization of the contents and discourses, the software identifies the (co)occurrence of words, cutting the text into context units and identifying themes or "classes of significant statements" (Reinert, 1986).

medical profession, iv) ambivalence of merit and equality, and v) the denial of gender inequalities (see Figure 1).

Figure 1

Thematic map with the main themes and subthemes



Gender dynamics of tokenism in medicine

Although each theme contains contributions from most participants, some display greater levels of representation. In the first major theme, young doctors prove the largest contributors (N = 7; five female and two male). We identified three major subthemes in the discourses on gender dynamics of tokenism in medicine: i) gender discrimination, ii) polarization of differences between male and female doctors, and iii) visibility of tokens.

Regarding the first subtheme including discourses on gender discrimination, most of the interviewed doctors, especially young participants, recognize that female doctors are discriminated and that male doctors are advantaged. Tokenism does not create the same conditions for both sex categories. Male doctors do not feel their errors or successes come in for greater scrutiny because they are men, while they recognize that this does happen with female doctors and that, as men, they do not need to prove their competencies. By contrast,

female doctors share the feeling that women have to prove themselves to be much better than men simply to achieve equality and point out that, particularly in the beginning of their careers, they have felt penalized as women and mothers and pushed to prove their competencies:

> "When a female doctor makes any mistake, she usually gets harmed more than men. And I think that when a woman is successful, she is less valued than a man achieving the same." [male, divorced, 33, sharing childcare of a child aged under 10, anesthesiologist]
>
> [Do you feel the need to prove your competencies?] Oh, yes, at the beginning it was really like that. We were constantly being overly evaluated, you know? And we were somewhat penalized, maybe for being women." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]

Male doctors never experienced any differential treatment between them and their female specialty colleagues that might potentially prove harmful to them; on the contrary, they sometimes felt that men are more valued. They have never felt excluded or ignored by their peers and they are sometimes the preferred interlocutor even when not head of department. Female doctors, however, point out experiences of differential treatment compared to their male peers, especially at the beginning of their careers, and prejudice in choices over training and career development opportunities on the ground of their sex. They also feel that some female leaders tend to treat male doctors better:

> [Have you ever felt differently treated in the specialty for being woman?] "There were differences regarding the treatment, there were no opportunities in surgery. In another hospital, there were. Here, there weren't, ever, that is what matters to me. Now, if you

> talk about discrimination, yes. In fact, the two men were very much spared in that regard, yes." [female, single, 49, surgeon]
>
> [How do your colleagues feel towards you?] "They feel a special appreciation for me. At this moment, it is the other way around, that is, I am one of the oldest in the service and I am the only man. So, alone in a female service, even to other colleagues, I sometimes become the preferred spokesman." [male, married, 53, three teenager and adult children, gynecologist]

In conclusion of this first subtheme, the fact that male participants recognize their advantages has to be underlined, because the research on gender inequalities shows generally that men deny it:

> [Have you ever been or felt individually discriminated against in your career?]
>
> "Because I'm a man? I don't think so. Personally discriminated against, favored or disfavored? It's difficult to isolate that, besides, I don't know. In terms of career progression, women face disadvantages because they might lose time, miss deadlines, because of maternity." [male, divorced, 57, living with his adult child, psychiatrist for children and teenagers].

Another subtheme deals with the stereotyped discourses about what it is to be a "man" or a "woman" in medicine. Among our participants, there is a consensual discourse on the differences between male and female doctors, their interests and behaviors. Male doctors stress differences in abilities and capacities for leadership, decision-making and managing difficulties, they consider that men are usually more tolerant, understanding and sure of their own decisions and cope better with stressful situations than women. Female doctors consider that conflicts are more common in services where women are the majority, describe women

as pettier, attributing more importance to "side issues" as well as being more complicated and less practical than men, who are also seen as more focused on gaining senior positions:

> "As everything in life, men are different from women and have different interests. I do not know. Conversations are different, I mean, a group of women, only women just have, immediately, different conversations to a group of men, only men." [male, married, 35, two children aged under 10, pediatrician]
>
> "In general men are more tolerant, less competitive and more understanding." [male, married, 62, two adult children, anesthesiologist].
>
> "We end up paying too much attention to those small little things. Thus, we are pettier than men. Maybe. It doesn't mean that this is universal. But usually in a service where there are a lot of women things are usually messier than in a service where there are a lot of men, because they are typically more practical, while we are typically more complicated (laughter)." [female, married, 33, pregnant, orthopedic surgeon]

As regards the visibility of tokens, male and female doctors alike show clear awareness of their higher visibility as tokens in their own specialty. For example, when we asked the participants if they had ever felt like tokens, most doctors responded similarly to the following excerpt from a female doctor:

> "Yes, they all know my name. But that's normal. It's like this, we, women, are fewer so everyone knows my name." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]

The effects of this visibility are not the same for male and female tokens. If we have seen before, in the first subtheme, that visibility is an advantage for male doctors, we note, in this last subtheme, that female doctors experience a feeling of negative role entrapment. They

were sometimes treated by their peers as less strong and more fragile than men, or pushed towards feminine specialties. This happens particularly in cases of specialties where the number of women remains very small as in urology. For example, a female urologist felt forced into the area of urogynecology by both colleagues and female patients who prefer female doctors in this specialty:

> [What do you think are the expectations of your male colleagues towards you, as a woman practicing urology?] "It is obvious that I am going to urogynecology [according to the expectations of others]. What they don't know is that urogynecology is what I hate the most in urology. It is the area I hate the most. I know they have that expectation. Those who show me the most discrimination are other colleagues from other specialties." [female, married, 33, two children aged under 10, urologist]

This first theme, which gathers the greatest number of transversal discourses, highlights the importance of tokenism, in particular as regards the gender discrimination and the differential treatment, the higher visibility and the feelings of role entrapment. The consequences of tokenism are completely embedded in gender hierarchy prevailing in the medical field: women are more disadvantaged and men are more stimulated, as recognized by both female and male doctors, especially the younger.

Family-work balance obstacles and strategies

Although all participants contributed to this theme, married doctors of both sexes (N = 9, five female and four male doctors) contributed more than single doctors. We identified three subthemes regarding reconciliation: i) forms of family-work balance, ii) dual employment as an obstacle to reconciliation for men, and iii) managing family life and medical career development for women.

Both male and female doctors said they are able to conciliate their professional activities and family life, even while this clearly proves harder for younger professionals, with children and working shifts. The factors highlighted as responsible for causing the greatest difficulties were the practice of extended emergency service shifts (24 hours long), changing shift patterns and extra-hospital activities (e.g., in private hospitals, clinics and offices). To manage this reconciliation as best as possible, most respondents depend on assistance from third parties, for instance, family members, daycare facilities or housemaids. This assistance is particularly important for the careers of female doctors given the fact that their conception of housework is not the same as that of men, who overestimate their real contribution to housework: according to male doctors, domestic tasks and child care are shared (e.g., they say that they cook, pick up their children from school and bathe them), but according to female doctors, these tasks are fulfilled by women or by a third party and they end up fully managing the household tasks:

> "If we share? Of course we do. Yes, yes, yes. Sometimes I like to cook, my wife also." [male, divorced, 57, four teenager and adult children, gynecologist]
>
> "I can conciliate it with a high level of dependence on third parties. Some wonderful grandparents, both on the dad's side and on the mom's side. The four of them are retired. I have huge support. I am a very lucky person (…). Then I have M, a fantastic person who takes care of the house and who sometimes also takes care of the children. And 'sometimes' is almost every day (…). All the family management, shopping, it's me who does everything. He does nothing. He works. He earns money and puts it in the bank." [female, married, 33, two children aged under 10, urologist]

A majority of interviewees maintain that, considering the profession's demands (e.g., one of the biggest burdens identified is total availability), the salaries are too low. Hence, and

to obtain a certain level of "financial comfort", respondents feel the need to engage in private sector activities beyond their public service assignments. However, these extra-hospital activities are most common among male doctors and, in this context, the balance between careers and family life is not really their problem, but the problem of female doctors:

> "My wife also works, but we decided that she would only have one job in order to be free at three o'clock and I would do the extra private job" [male, married, 53, three teenager and adult children, gynecologist]
>
> "Colleagues from other specialties can make some more money doing some extra shifts. But I think it's very sweaty money if you ask me. Not being home, very bothersome schedules, completely distorting a person's rhythm, a person's sleep. Me, when I was doing shifts, I always had this weariness that I don't have now." [female, married, 35, one child aged under 10, sports medicine]

The persistence of the burden of housework and family duties may be one reason why women do not choose masculine specialties in greater numbers. Furthermore, the expectation associated with this burden may contribute to postponing family life and maternity projects in order to assure greater professional availability:

> "For a lot of women today, those [being a housewife or having children] are delayed projects. Let's put it like that, they dedicate themselves to the profession and that's it. But well they themselves recognize that it is a heavy specialty. People are making fewer family options and all that. Today, people get married later and later, they put off having children more and more, all of that." [female, married, 60, urologist)]
>
> "There, I think that team leaders see, I suppose, availability and dedication. And if you see a man there every day, doing overtime because he can and because he has the time, and then you see a woman who has to go home to feed the children and all that, she

> falls behind because, in the end, she's not that available. And I think that in those very specific and very competitive specialties, it's very hard for a woman to get in…due to the availability issue." [male, divorced, 33, sharing childcare of a child aged under 10, anesthesiologist]

In medicine, especially under token conditions, the career is seen as requiring a high professional investment. This, however, does not mean that husbands of female doctors assume higher domestic investment. Thus, tokenism does not challenge the gender division of labor in the household.

Conceptions of the medical profession

This theme gathers the testimonies of male and female doctors, generally older (N = 10; four female and six male). Most of them do not have young children anymore. Discourses focus on three major subthemes: i) fundamental medical competencies, ii) personal traits, and iii) reasons for entering medicine and the reactions of others.

The spectrum of identified medical competencies is wide reaching within the set of abilities or competencies deemed fundamental. They include the calling or the vocation for the profession, interpersonal relational abilities, communication, theoretical and practical knowledge, technical competencies, teamwork skills, intelligence and availability or spirit of self-sacrifice, good judgment, clinical sense, attendance, observation, promptness and efficacy, physical and psychological strength, calmness, patience, stability, memorizing and flowchart thinking skills.

Personal traits are pointed out as relevant tools in the specialist fields. Doctors highlight their personal and professional abilities to place themselves within the boundaries of what they consider a good doctor, characterizing themselves as happy people, who like

their jobs, are technically good professionals, with good communication and interpersonal skills, organized, demanding and helpful:

> [Personally, how do you characterize yourself? As a person and as a professional?] "In that regard, I consider myself a very happy person, because I do exactly what I like. That is very important for professional fulfillment, for personal fulfillment, very important, isn't it? I have a very complicated family life, but when I'm dressed as a doctor, I'm different." [male, married, 53, three teenager and adult children, gynecologist]
>
> "Personally, I think I'm an organized person, I really like knowing what I can count on so there's nothing failing, I'm dedicated to the patients as well, but I'm also a bit anxious." [female, married, 57, one adult child, orthopedic surgeon]

In revealing the reasons that led them to choose the profession and their family's reactions, respondents highlight their fondness for healthcare and caring for others, the workings of the human body as well as the career perspectives. The reasons derive from how medicine gets perceived as fascinating, motivating, challenging and practical:

> [What were the reasons that led you to go into medicine?] "Between sports and medicine, medicine ended up taking on a bigger weight, more enticing, a bigger challenge, and also with more job perspectives. And it was a bit because I liked the healthcare area, the human body, its functioning, physiology, that's what made me choose this field. It wasn't, though, a 100% pure choice." [female, married, 35, one child aged under 10, sports medicine]

In general, the reactions of others to the choice of medicine were positive:

> "I don't remember wanting to be something else, I've always wanted to be a doctor. [Your choice for medicine caused reactions from family, friends, etc.?]. No. They were all used to what I wanted for myself; everyone already knew that I was going to be a doctor (laughs)." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]

The medical profession is generally presented as a motivated choice highly valued by the environment and the context of tokenism does not seem to influence this conception. However, most participants who addressed this theme in their responses are older and have no more children care duties: this generational difference in their private life can explain the quality and quantity of competencies and skills associated with a highly demanding conception of this profession.

Ambivalence of merit and equality

Most discourses, especially from male doctors (N = 8), are structured around three subthemes: i) the numerical discrimination of women as a past problem, ii) the present number of women as a threat for men, and iii) the individual merit as a guarantee of gender equality.

Both younger and older male doctors consider that discrimination against women in medicine is connected to the pre-democracy period (before 1974) and reckon that nowadays women are assured of access to higher education:

> [Why do you say that medicine was a men's world?] "Access of men and women wasn't quite the same due to cultural issues; women didn't have access to education, as they later started to have, especially higher education, right?" [male, divorced, 57, living with his teenage child, gynecologist]

> "Back then it was a masculine world, because there wasn't this, this selection bias (…). This selection bias, by gender/grade, started in the 90s and before that it was because there was no *numerus clausus*, right?" [male, married, 35, two children aged under 10, pediatrician]

In the last forty years, the proportion of women in medicine has radically changed from a minority to a majority, as stated in the introduction. Male doctors perceive this feminization as threatening:

> "What I think of this inequality [in medicine] is that men are at a distinct disadvantage in school and that school is an exclusion factor for men. [Why?] Because most people entering university are women because the educational system is prepared for girls. Being a boy, in school, becomes a factor of exclusion. People don't tolerate activity, aggressiveness, violent games, they don't tolerate restlessness. The values cultivated in school, which is dominated by women, by female teachers, are perseverance, passivity, persistence, holding up pleasure and satisfaction […]. In my opinion, there should be educational segregation. We should have a better understanding of how boys learn and how girls learn." [male, divorced, 57, living with his adult child, psychiatrist for children and teenagers]

Although this theme includes primarily the discourses of male doctors, we found that male and female doctors are unanimous in their opposition to affirmative action programs, such as university entry quotas, as they are seen as contradicting two important and shared norms of justice: individual freedom and merit. These principles of justice dominate their discourses which stress "the value of the person" and the person's merit, whereas quotas are seen as some kind of "certificate of incompetence" to the candidate. Furthermore,

respondents perceive the current situation as non-problematic as long as people enter medicine of their free own will and they think that equality can be reached 'naturally' with time:

> [What do you think about quotas?] "I don't think there should be quotas. There shouldn't be quotas for being male or female. It is what the person naturally is. You make the entrance exam, you make that exam to enter the specialty and then you go to where you please and to where you can according to the exam grade." [female, married 57, one adult child, orthopedic surgeon]
>
> [Are you in favor of quotas or not?] "No, no. I think to go into medicine we must enter by merit (…). I think that one should not minimize the merit of those who have it. So I do not agree with quotas in almost any circumstances. I think that either a person has merit or does not have it. What is important is to check if it is by merit or by something else." [male, divorced, 33, sharing childcare of a child aged under 10, anesthesiologist]

Hence, individual freedom and merit appear as the guarantees for gender equality in medicine and, for male doctors in particular, the only means of opposing the threat represented by what they deem the tendency to marginalize males. On this theme, individual and naturalistic explanations of social problems are stressed.

The denial of gender inequalities

Fourteen participants, especially mothers and older women, contributed to this theme, which covers dispersed discourses sharing gender equality issues (as the fourth theme) and personal experiences in medicine around discrimination, its naturalization and denial:

> [About your inclusion in this "man's world", as you say, do you remember an example?] "When I got here, after a day or two, he [the director] called me in to ask me

> if I really wanted to do this, if I really wanted orthopedics, that it was a specialty that required a lot of strength, that there was a voluntary female colleague here but that she had a karate black belt, that she was a very big woman, and didn't I really want child orthopedics? And I said no, that I wanted adults, that I didn't like working with children." [female, married, 57, one adult child, orthopedic surgeon]
>
> [When we look at the representation of men and women in medicine, we still see a numerical difference, particularly in some specialties. What do you think about this situation?] "In this hospital, there are more girls. There are some already in urology, I noticed that in congresses. I already see a lot more girls, a lot more women in orthopedics than before." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]

Despite the positive progress towards a quantitative equality, qualitative advances are lacking. Indeed, female doctors put forward the hierarchical structure of the medical specialties, particularly urology, orthopedics and surgery, which remain male-dominated professions for reasons that have to do with the specialty and the profession:

> [Why do you think that there is this difference in gender numbers?] "In orthopedics, I think that maybe it has to do with the specialty itself, with the nature of the specialty, it is maybe not that feminine a specialty." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]
>
> "I think it has to do with the specialty itself. It's what I already mentioned, that orthopedics is associated with strength. Strength = man. And urology for working… for dedicating itself to the male sexual organ. So, I think it has to do with those two strands." [female, married, 57, one adult child, orthopedic surgeon]

Both male and female doctors believe that shifts in gender numbers would not lead to changes in the "way that medicine is done":

> [What do you think would cause the entry of more women in 'male specialty areas' and the entry of more men in 'female specialty areas'?] "With the entrance of more women, I don't think a lot would change. 50/50 is not bad at all, 50/50 is more or less balanced but it wouldn't change much." [female, divorced, 50, living with her teenager and adult children, orthopedic surgeon]
>
> [I always wanted to understand why medicine is a 'man's world'.] "Women are super-essential in medicine. As with everything in life, I think that women are fundamental. But I think that an excess of women is as bad as an excess of men. I have no doubts about that, I think balance is good." [male, married, 35, two children under 10, pediatrician]

Discourses on discrimination, evoking the past and rejecting this reality in the present, also insisting on medicine as a "gender neutral" profession, converge to a denial of gender discrimination as a structural element. This strategy, mostly used by women, appears as a way of facilitating their integration in a professional environment that remains hostile towards them.

Discussion

Generally, the results of this study highlight the advantages held by male doctors over female doctors: the dynamics registered in their case under token conditions are similar to those evidenced when men are the dominant group, as reported by Budig (2002) in the United States. This similarity suggests that the hierarchy of gender categories determines experiences

more than tokenism. If tokenism has gender effects of discrimination, it is only because it strengthens this hierarchy.

Although the responses from participants enabled the identification of the tendencies in perception associated with tokenism in Kanter's model (1977, 1993), our research shows that these dynamics are shaped by the dominant position of males and not by the token status of male or female doctors. All participants experienced high visibility from being tokens (e.g., all colleagues know their name, or how many men/women are in the specialty area), but the consequences of visibility differ. Male doctors, particularly the younger, feel neither the need to prove their competence nor that their errors or successes come in for greater scrutiny; on the contrary, female doctors do feel as though they have to prove their competence, particularly when beginning their careers and experiencing discrimination both as women and as mothers. Regarding the contrast or the polarization of differences, male doctors have never felt excluded nor ignored by their peers, feeling instead either that female doctors always seek to integrate them or that they come in for preferential treatment and that both male and female peers value and praise men more than women. Female doctors, by contrast, reported differences in treatment between them and their male peers when beginning their professional activity, in terms of career progression opportunities and disadvantages due to their sex. Finally, as regards the group assimilation of stereotypical roles, feelings of negative role entrapment only emerged amongst female doctors whose colleagues treated them as weaker and more fragile than men, and pushed them towards feminine specialties. Male doctors reported role entrapment examples that favor them based on expectations as to their leadership skills. Thus, this gender difference drives positive results for males, pushing them up the ladder into leadership positions.

These gender asymmetries in token conditions are generally recognized both by male and female doctors. This is an interesting result because gender inequalities are more

commonly denounced by women in all domains of life. For example, in our research, some male doctors perceived that their female counterparts suffer greater penalties for their errors and are less valued for their successes. Others recognized that maternity is an obstacle for career progression. This suggests that tokenism highlights not only the visibility of minorities but also the visibility of inequalities, here of gender.

One of these gender inequalities is the balance between family and work, since the weak participation of the Portuguese men in the family care related activities constitutes a source of discrimination for women (Amâncio, 2007), a fact that the men resist to recognize. This resistance creates a gendered dissent, which is not specific only to Portugal or to doctors or to individuals in token positions (e.g., see De Singly, 2007; Roux, 2014). The fact that the family role represents an obstacle to careers only for women is reflected in another result of our research: male doctors exercise multiple remunerated extra-hospital activities. It is not an obstacle to their career, and, at the same time, it legitimizes their low level of participation in the family sphere. This persistent burden of housework from which the men are freed by our respondents as by society in general (as shown by Crompton & Lyonette, 2011; Evans, 1997), may well represent a strong reason behind the absence of women in masculine specialties requiring both high availability and investment.

Participants indeed perceived their profession as demanding and requiring a great variety of competencies and skills. This is a masculine conception of the profession, which does not take into account other life projects and may restrain the medical careers of women. But this gendered vision of the profession is more clearly embraced by the older generation of doctors: it suggests that the integration and the legitimacy of women in the masculine areas of the medical field might improve in the near future.

However, such a hypothetical gender change may also be slowed down by the strength of meritocracy. Our research shows ambivalences in dealing with merit and equality.

For male doctors, as the presence of women is already threatening, any additional affirmative action such as quotas gets strongly rejected in the name of merit. For women, whose competencies are still questioned and mistrusted as a result of gender stereotypes, merit becomes a value to protect their self-esteem. Therefore, the persistence of gender inequalities in the medical profession in a context of tokenism is explained by personal traits and choices better than by social conditions like the gender hierarchy. Additionally, when female doctors point at this hierarchical structure, they see it as a consequence of the "nature" of the specialty and the "neutrality" of the profession. As a result, both women and men refuse to integrate social conditions, in particular gender, in the medical profession. But they refuse to do it in different ways: men tend to stress merit as a superordinate value, while women show their concern to adapt to the dominant model of the profession.

In sum, the discourses surrounding gender inequalities and difficulties for change reveal tension and gender awareness deficit. The tension relates to the fact that the success of women in accessing the medical profession is seen as a source of personal concern and not as a social progress issue, and that this success is explained within the dominant meritocratic ideology. To cope with this tension, respondents establish a dichotomy between the past and the present that highlights the barriers put in place under the dictatorship[2] to women's access to medicine in general, and masculine health specialties in particular, which were removed after the advent of democracy in 1974. But contrary to the case of the diplomatic and legal professions, there were no legal impediments for women to enter medicine in the past, there was rather a strong ideology differentiating between the gender roles that justified both the objective and subjective barriers with maternalistic arguments. Paradoxically, the

[2] From 1926 to 1974, the Government values were very conservative, defending a traditional domestic role for women. In 25 April 1974, the military coup marked the end of the authoritarianism in Portugal and conducted to a democratic regime. In 1976, the principle of equality was formally guaranteed by the Portuguese Constitution.

justifications regarding the persistent inequalities between men and women in the profession appeal to a naturalist discourse that reproduces past prevailing reasoning, despite the perception that the latter is overtaken. The difficulty in understanding the social character of gender processes thus translates into a sort of individual *de-responsibilization* for social change which contributes to the reproduction of the gender order.

To conclude, tokenism dynamics are inscribed in this gender order, since the token position is primarily understood as an individual choice, not a challenge for gender hierarchies. Although the token position occasionally produces gender arrangements, such as the recognition of some gender inequalities, it does not transform asymmetric gender positions either in the professional field or in private life.

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