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How Women Change Medicine

A Case Study in a German Hospital

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1 Introduction

1.1 Female Physicians and the Medical Profession

In the past few decades, the number of women who participate in medical schools has increased significantly in Germany (Statistisches Bundesamt, 2011-2012). Until the early 90's, the medical profession was mainly male dominated. This changed during the 1990's when more women took part in medical studies. Currently, 60% of the physicians under the age of 35 are female and almost 70% of the medical students are women, possibly leading to an even bigger amount of female doctors in the future (Radtke, 2009; Statistisches Bundesamt, 2011-2012). This trend is not only visible in Germany; also the UK and other European countries experience this so called 'feminization of medicine[1]' (Riska, 2001; Heru, 2005; McKinstry, 2008).

In the past years, the feminization of medicine has repeatedly been discussed by scholars and physicians whose thoughts and opinions differ vastly (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007). These discussions refer not merely to numbers and statistics; the term 'feminization' is also used to describe the qualitative changes in the profession. In some cases, feminization is equated with weakness, powerlessness and decrease (Britton, 2000; Riska, 2008). Doctors like Brian McKinstry and Carol Black for example, fear that the increase of female physicians will do harm to the profession because they figure that women are not efficient enough in treating their patients (McKinstry, 2008), and are not taking on demanding jobs such as surgery (Carol Black in Khan, 2012). There is also concern among some physicians that the

[1] The feminization of medicine refers to an increase in the number of female physicians working in the profession. But, as scholars like Riska (2001; 2008), Boulis and Jacobs (2008) a.o. argue, in many instances, the term refers to much more than an increase in number alone and also indicates qualitative changes. I will reflect on the multiple meanings of feminization in paragraph 2.1, but since I do not start this thesis with the assumption that an increase in women doctors automatically means a qualitative change in the profession as well, I use the term feminization to point to a numerical increase in female physicians.

increasing number of women working in the field will result in the decline in status and payment of the job. As Carol Black argues: "It is a case of downgrading professionalism" ("Women Docs 'Weakening' Medicine", 2004). On the other side of the spectrum, there are scholars who welcome a feminization in medicine. Jane Dacre, for example, does not foresee any problems at all, and rather refers to the increase in female physicians as a chance to change work structures within the profession (Dacre, 2008).

Besides debating the status of the profession and its organizational planning, the discussion on the matter also focusses on how an increase in women doctors changes the practice of medicine itself. It is often suggested that as their overall representation increases, women physicians will alter the content and practice of medicine, making it a more caring and patient-centered work-field (Riska, 2001; Riska, 2008; Dacre, 2008; Boulis and Jacobs, 2008). These assumptions are based on the idea that women practice medicine differently from men because women harbor different qualities from men and that these qualities will make them more empathic and caring as physicians than men.

1.2 The Current Situation in Germany

Besides undergoing a feminization of the medical profession, Germany is also experiencing a shortage in physicians (Hofmeister, Rothe, Alfermann, Brähler, 2010). A study conducted by the *Bundesärztekammer* showed that in 2012, more than 6000 positions remained unfilled. Although measurements have been taken over the past years to deal with this shortage, currently, there is still a deficiency in hospitals as well as practices (Bundesärztekammer, 2012; Roland Berger Strategy Consultants, 2013; "Zahl der Ärzte steigt", 2015). Because of this deficiency, it is expected that not only more women will enter the medical profession, but will also have more room to express and convert their wishes concerning family-friendly work structures. As a

medical journal in Germany explains, ever more women set these kind of structures as a precondition for taking a job position, which in turn could result in changes in the profession (Levinson and Lurie, 2004; Meyer-Radtke, 2009; "Feminisierung der Medizin", 2014).

1.3 Focus of the Dissertation

This dissertation discusses the influence of the feminization of medicine on the medical profession. The discussion on the feminization process is based on the assumption that women are different from men and therefore work different than men. Although I do not deny the existence of gender differences, I am careful to propose them as a given factor. I see gender differences not as a natural fact but rather as a constructed social position. I therefore use Judith Butler's theory on gender identity as performative in order to investigate how gender specific behavior influences the medical profession. In her book Gender Trouble (2010), Judith Butler introduces the philosophy of performativity. Butler argues that gender is performatively produced and constituted by the expressions that are said to be its results. There is no ontological gender reality except for the one that is constituted through its various acts (Butler, 2010). Furthermore, the interior essence that is fabricated is an effect of public and social discourse (Butler, 2010). This means that gender identity has no fixed ontology, but is rather a product of expressions that constitute its reality. West and Zimmerman (1987) have a somewhat similar opinion on gender identity referring to its construction as 'doing gender'. They do not see gender as an internal part of an individual but rather as an achieved property of situated conduct; individuals *do* gender. Therewith, it is not only a property of individuals but also of social situations and institutions (West and Zimmerman, 1987). Gender identities are a fundamental component of the social realm including work and work life. Gender as a category is constructed by and in work life through the

division of labor and in the workplace. As Acker explains in her works on gendered organizations, gender identities are formed and changed as men and women participate in work processes resulting in ideas on typical masculine and feminine traits that in turn become linked to jobs (Acker, 2012). In the case of the feminization of medicine, the question that needs to be investigated is thus not only if and how women influence the medical profession, but also how medical institutions construct gendered identities.

As these theories elaborate, gender identity is not something that naturally shows itself in male and female behavior but rather somethings that is created in relation with and mediated by society. Many sociologists have researched the influence of social structures on the behavior of individuals. As well Anthony Giddens (1987). Although he does not refer to the production of gender identity in his works on structuration, his theories do elaborate on the interaction between structure and personal agency. According to Giddens, structure establishes the context in which agents act and these agents simultaneously shape this context through situated actions (Giddens, 1987). Although Giddens does not take on the question of identity, his theory can be used to analyze how social contexts influence the 'gendered' actions of agents and how these actions simultaneously influence structures.

In this dissertation, an emphasis is put on how the increase of female physicians influences organizational structure and culture in the hospital, and how these in turn determine the way men and women perform their job. Feminization proposes a qualitative change in the medical profession. This is based on the idea that men and women show gender distinct behavior. The aim of this dissertation is to deconstruct the idea that women change medicine because they naturally practice care differently from men and to rather look at how men and women influence – and are simultaneously influenced by – organizational structures and culture and what this means for the effects of the feminization process on the profession.

1.4 Research Context

Throughout the years, a lot has been written on women and medicine. Besides articles and reports in newspapers and magazines, there is a vast body of research done by scholars and physicians who focus on the development of women in the medical profession (Elston, 2009; Boulis and Jacobs, 2008). Some of these scholars concentrate on the discourse surrounding the phenomenon, pointing toward the problematic use of the term feminization, the essentialist notions of masculinity and femininity underpinning the debates, and the deeply gendered organization of medicine (Riska, 2001, 2008, 2012; Tsouroufli, Özbilgin, Schmidt, 2011). Others, like Kilminster et al. (2007), Boulis and Jacobs (2008), and Elston (2009) have investigated the probable future effects of the increase in female physicians.

Through a literature review, Kilminster et al. (2007) have explored the effects of the changing gender composition in medicine on the profession. Their research suggests that when more women enter the profession, this will have implications on workforce planning given that more women are likely to work part-time. Furthermore, the increasing number of female physicians will affect the way in which health care is performed and delivered (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007). Other works analyzed by Kilminster et al. state that the feminization process will not have a major influence since medicine has rigid structural inequalities that preserve male dominance (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007). The conclusion of the review is that the evidence for the assumptions on women's distinctive practice style is contradictory. Although some scholars point to differences in communication, there are only few, if any, enduring differences in the way men and women practice medicine. The article closes with a discussion and recommendations for further research stating that: "[…] there is a need for further research to investigate the complexity of gender-related phenomena within medical education in particular and medicine in general" (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007 p. 45). And that: "To understand the effects of the

changing gender composition of medicine it will be necessary to use more sophisticated research designs to explore the structural, economic, historical and social contexts that interact to produce medical culture" (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007, p. 39).

Elston (2009) did a study in the UK based on literature research, secondary analysis and qualitative data collected through interviews with key informants. The questions and outcomes of her research focus on four main subjects: entry to the profession, specialty preferences and choices, modes of working in medicine, and advancement and leadership within medicine. Elston concludes that the increasing number of women entering the profession will have major organizational implications. Men and women show differences in workforce participation, with women more often taking part-time jobs than their male colleagues. She proposes that increasing the possibility for flexible working options will become necessary in order to accommodate the influx of women in the work field (Elston, 2009). The paper gives a good overview of the work patterns and career choices of female physicians, but does not elaborate on the influence of medical culture and organizational structures on the work patterns of women. Neither does it focus on the assumed change in medical performance, two aspects that in my opinion are important to analyze if the specific effects of the feminization of medicine are to be investigated.

Another extensive research is conducted in the USA by Boulis and Jacobs (2008). The study gives a broad overview of the development of women's participation in the medical profession. In their book called *The Changing Face of Medicine* (2008), Boulis and Jacobs pose the question whether gender differences in medicine are the result of the choices made by individual women, or if gendered institutions also play an important role? They state that: "women's entry into medicine is seen as dramatic evidence that the barriers to opportunities for women are rapidly falling in America. Does the experience of female physicians to date bear out this optimistic view? An alternative view is that gender roles remain deeply entrenched in our institutions and culture" (Boulis and Jacobs, 2008, p. 8-9). Besides giving an all-encompassing overview

of the development of women's entry into the medical profession, they elaborate on the gendered nature of the field and the persistence of gender segregation between specialties and on the hierarchical level. Their explanation for this is that specialties tend to be self-reproducing social organizations, and thus continuity over time is to be expected. Secondly, the gendered culture within medicine sustains a relationship between women's specialty choices and the beliefs about personal traits best suited for specific jobs (Boulis and Jacobs, 2008).

Besides women's influence on organizational structures, Boulis and Jacobs also elaborate on the discussion that women are better caretakers and more empathetic with patients. "It is often suggested that as their overall representation increases and, more specifically, as their presence in leadership grows, women physicians will transform American health care, making it a more caring, patient-centered institution" (Boulis and Jacobs, 2008, p. 132). Their research shows, however, that differences between men and women in treatment patterns such as communication style and empathy are relatively small. The results of the studies are very mixed and when gender distinctions are detected, the differences are little. In the end, Boulis and Jacobs (2008) argue that gender difference in practice style appears to be strongly tied to differences in the social pressures and structural realities that male and female physicians confront in the everyday practice of medicine. "Physician's empathy and communication styles are primarily determined by social forces such as daily interactions with patients and colleagues rather than by fixed, biologically determined characteristics" (Boulis and Jacobs, 2008, p. 143). The authors conclude that the change women will bring into medicine might be more limited than current debates suggest since independent changes in the structure of medicine are constraining the ability of physicians to provide more patient-centered care (Boulis and Jacobs, 2008). Although, in my view, they rightly point to the constraining mechanism of organizational structure on the practice of medicine, they do not elaborate on the enabling side of structures, or leave room for personal agency.

Furthermore, they do not specify how these structures influence the way men and women perform their jobs. Therefore, in this dissertation, I investigate how the positions of men and women within the medical organization are formed and (re)produced by (gendered) organizational structure and culture and how these interact with the performances of the physicians.

2 Theoretical Background

2.1 Feminization

The term feminization is not unproblematic or at least needs to be discussed with regard to its content before using it in this dissertation. Feminization can have multiple meanings. The term is generally used in reference to the increase of women in areas that have previously been male dominated (Fondas, 1997). With regard to the feminization of a profession, it points to "women's disproportionate entry into customarily male professions" (Fondas, 1997, p. 258). The discussion on the feminization of medicine, though, shows that the term refers to much more than an augmentation in numbers alone. It contains predictions about the qualitative changes as a result of the feminization process. The assumption is that an increase in female physicians will alter the profession of medicine because men and women have essentially different qualities and therewith bring something different to the job (Riska, 2008; Riska, 2001; Ulstad, 1993). In a literature research on the medical discourse surrounding the feminization thesis, Riska (2008) describes the different perspectives that medical journals have presented on the matter. An article published in the *British Medical Journal* in 2004 suggests that the feminization of medicine will result in a downfall of rationality (Riska, 2008). Doctors like Brian McKinstry and Carol Black share this opinion. They fear that the increase of female physicians will do harm to

the profession because they figure that women are not efficient enough in treating their patients (McKinstry, 2008), and are not taking on demanding jobs such as surgery (Black in Khan 2012). There is also concern among some physicians that the increasing number of women working in the field will result in the decline in status and payment of the job (Riska, 2008). As Carol Black argues: "It is a case of downgrading professionalism" ("Women Docs 'Weakening' Medicine", 2004). The implicit argument here is that medicine will only remain a high status profession as long as it continues to be male dominated (Boulis and Jacobs, 2008; Riska, 2001). It is also stated that structural changes will emerge due to women's high demand for part-time work. Although some see this as a problem (Heru, 2005; Black in Kahn, 2012), others, like Jane Dacre, see feminization as a chance to change work structures within the profession ("More Doctors Needed", 2004; Dacre, 2008). Dacre states that it might be an incentive to be more creative with workforce planning and take on a more flexible approach to work hours. "This change to a more flexible way of working will be more acceptable to colleagues with domestic and other commitments and is likely to result in more women taking on leadership positions" (Dacre, 2008, p. 749).

Besides structural changes, it is foreseen that the increase of female physicians will also influence the provision of care. Many physicians and scholars alike argue that a majority in female doctors will give rise to a more humane and patient-centered medicine (Heru, 2005). This argument is based on the assumption that women are naturally more caring and empathic and bring these skills with them in the practice of medicine (Riska, 2008; Heru, 2005; Gray, Fabre, Brown, Des Spence, 2004; Riska, 2001; Ulstad, 1993). The discussion on the feminization of medicine elaborates how the increase in female physicians will not only give the profession a different image and status, but also alter its content and 'nature'. Riska a.o. has a rather critical stand toward this thesis. She rightly poses the question to what extent "women physicians represent a vanguard within the profession, which will head the rest of the profession towards a substantial change in the way medicine is practiced; or has such a potential

been coopted by a still predominantly male profession that continues to relegate women to marginal positions" (Riska, 2001, p. 180)? She also points to the fact that women doctors do not work in a universal organizational context (Riska, 2001). Therefore, it is important to specify the organizational context in which feminization takes place and execute a comparative study in order to lay bare the diversified effects of the feminization process.

Where the discussion on the feminization of medicine has pointed out many factors that need to be taken into account, two factors remain underexposed. First, gender identities are not a natural given, but rather socially constructed through actions. Secondly, medical institutions are never gender neutral workplaces but sites where gender identities are produced, as will be elaborated further in paragraph 2.3 on gendered organizations.

2.2 Gender Identity

In Western societies, men and women are defined categories of being (West and Zimmerman, 1987). The accepted cultural perspective sees men and women as distinctive subjects with "psychological and behavioral propensities that can be predicted from their reproductive functions" (West and Zimmerman, 1987, p. 128). In other words, biological differences between men and women result in distinctive gender behavior. These distinctions are presented as natural, fundamental and unchangeable (Garfinkel, 1967 in West and Zimmerman, 1987). I, and with me many others, do not see gender identity as a stable category, neither do I perceive the differences between men and women as natural.

In her book *Gender Trouble,* Judith Butler (2010) problematizes the concept of gender identity. Instead of approaching identity as fixed and static, she argues for a perception of identity as fluid and in a continuous state of becoming (Butler, 2010). In her book, she introduces the philosophy of performativity. She argues that gender is

performatively produced and constituted by the expressions that are said to be its results. There is no ontological gender reality except for the one that is constituted through its various acts (Butler, 2010). This means that identity has no fixed ontology, but is rather a product of expressions that constitute its reality. Instead of having an essential core, identity is thus perceived as fluid and constantly changing according to the way it is expressed. Butler starts her book by stating that gender categories are normative, exclusionary and repudiating the multiplicity of cultural, social and political intersections in which individual identities are constructed (Butler, 2010). She stresses that gender is not always constituted coherently in different social contexts but is rather affected by racial, class and ethnic features. When talking about identity, it is impossible to separate gender from political and cultural intersections in which it is produced (Butler, 2010).

West and Zimmerman (1987), in their paper on *Doing Gender,* also refer to the importance of cultural and social context when it comes to analyzing identity. They argue that men and women do not have an internal gender, but construct an identity by *doing* gender. Through various activities, men and women reflect or express gender. West and Zimmerman refer to gender identity as "an achieved property of situated context" (West and Zimmerman, 1987, p. 126). This means a shift in focus from gender difference as internal to gender identity as constructed in and through interaction. Gendered identities are acquired in relation to other individuals, ideologies and institutions etc. Doing gender, therewith, is a situated action; men and women act in relation to their social context (West and Zimmerman, 1987).

One of the areas in which gender identities are constructed is the workplace. Through actions inside and outside the corporation, gender identities are created. In her work on gendered organizations, Joan Acker (1990) explicitly refers to this phenomenon arguing that gender is not a static internal fact, but an identity category that is created through actions inside and outside the workplace.

2.3 Gendered Organizations

Before discussing how organizations are gendered, it appears useful to give a definition of what an organization is. According to Jones, an organization is "a tool people use to coordinate their actions to achieve their goals" (Jones, 2013, p. 24). It consists of a group of people that use their actions in order to obtain something. Organizations are not isolated entities; they affect and are in turn affected by their environment. When studying how they function, three components need to be in focus; organizational structure, organizational culture, and organizational design and change (Jones, 2013). Organizational structures control how people coordinate their actions. It is a formal system of tasks and helps to increase the effectiveness of the organization in order to achieve its goals. Organizational structure can be managed through the process of organizational design and change (Jones, 2013). Organizational culture is a set of shared values and norms that guides and controls interaction between members and their behavior (Jones, 2013). New members of the organization have to make themselves familiar with the established norms and values in order to become insiders (Jones, 2013). Organizational structure and culture emerge simultaneously; they coevolve. Therewith, development of an organizational structure is inextricably related to the development of its culture and the other way around (Bate, Kran, Pye, 2000).

Although gender plays a fundamental role in both organizational culture and structure, sociological research on the functioning of organizations has hardly paid any attention to gender at all. For a long time, organizations were perceived and presented as gender neutral institutions (Acker, 1990). This changed during the 1970's, when scholars like Rosabeth Moss Kanter (1977) started to point toward the gendered nature of organizations. In her extensive research on the distribution of power within the corporation, Moss Kanter argues that gender differences in organizations are due to structure rather than the characteristics of men and women as individuals. The problems women face are a consequence of their structural placement, not their

behavior (Moss Kanter, 1977 in Acker, 1990). Moss Kanter is the first scholar who examines the interplay between gender and the organization and the first one to identify the problem of presenting organizations as gender neutral. At the start of the 90's, scholars like Acker (1990; 2012) and Britton (2000) took up the work of Moss Kanter, using it to further develop theories on women and organizations. Acker has a critical stand toward the works of Moss Kanter, arguing that she puts too much focus on structure instead of gender. As a result, gender is placed outside of structure, which according to Acker can never be the case. Gender is not an addition to organizational processes, but an integral and constitutive part of it. As Acker shows in her analysis on the gendered nature of organizations, gendering occurs in five interacting processes: organizational structure, organizational culture, interaction on the job, individual identity and organizational logic. These five processes construct what she calls the gendered substructure of an organization (Acker, 1990; Benschop and Doorewaard, 2012).

The first of this set of processes is the construction of divisions along the lines of gender: "divisions of labor, of allowed behavior, of locations in physical space, of power, including the institutionalized means of maintaining the divisions in the structures of labor markets, the family, the state" (Acker, 1990, p. 146). Acker refers to these as organizing processes where inequalities between men and women emerge because of how jobs are designed, wages are determined and decision-making is distributed (Acker, 1990; 2012). Organizing processes are based on the division of labor; the separation of family and work life. Traditionally, women stay at home to provide care work whereas men work in the public sphere. Since care work in the private sphere is not rewarded like work in the public domain, this division leads to inequalities between men and women. In organizations, private matters like social reproduction and care work should not interfere with core workplace processes, automatically making women less favorable for jobs than men (Lewis and Humbert, 2010). The division of labor not only occurs between the private and the public sphere, it also emerges within the organization itself with men and women having different

occupations and positions. Typical women's jobs such as teaching and caring are often valued less than men's occupations like finance and business and men often hold high rank positions whereas women remain in the lower ranks. This distribution of jobs along lines of gender is referred to as horizontal and vertical segregation with horizontal segregation referring to women's specific jobs and vertical segregation to gender differences in high and low rank positions (Durbin and Fleetwood, 2010; Leinonen, 2012; Wilz, 2001; 2004).

The second process is what Acker calls organizational culture. It is the construction of "symbols and images that explain, express, reinforce or sometimes oppose those divisions" (Acker, 1990, p. 146). These symbols and images not only reflect but also construct beliefs about gender difference. Additionally, organizational culture defines accepted and therewith unaccepted gender behavior. It dictates and legitimizes how men and women are supposed to behave (Acker, 2012). The culture of an organization is placed in the larger cultural terrain of the surrounding society. Images of men and women in society are reflected in the organization and the other way around (Acker, 2012). Stereotypic images of women and men play an important role in the construction of gender difference. Stereotypes are a set of subjective and often overgeneralized beliefs about personal characteristics, attributes and behavior of a group of people (Gardner, Macyntire, Lalonde, 1995; Ganter, 1997). Stereotypic images in the organization are not only a reflection of these beliefs, but also become internalized, therewith dictating the actions of individuals (Durbin and Fleetwood, 2010). Part of the medical organizational culture is the image of a good doctor that is supposed to have certain attributes and characteristics and behave in a particular manner in order to fit the picture.

The third process that composes the gendered substructure of the organization is interaction between individuals in the workplace. Through both formal and informal interactions on the job, the gendered substructure is being reproduced. The fourth point that Acker mentions is the gendered components of individual identity. Gendered identities are brought into the organization by individuals, but are also

formed and changed in work processes. How people perceive themselves is influenced by the other three processes mentioned above (Acker, 1990; 2012). As declared earlier in this dissertation, gendered individual identities are not a natural and static internal essence, but constructed by and through the interaction between an individual and its environment. Organizational structure and culture and the interaction between people thus influence the construction of individual identity and therewith the actions of men and women in the workplace.

The last point that Acker remarks is that gender is constitutional in the framing of assumptions and practices that underlie organizational structures. She calls this organizational logic; assumptions and practices that construct most work organizations (Acker, 1990; 2012). Organizational logic contents rules and expectations that come with jobs. You need to be at work at a specific time, for a certain amount of hours and work needs to have your undivided attention. These rules seem to be gender neutral, but they are not; "they are implicitly built on the image of a gender neutral, abstract worker who has no body and no obligations outside the workplace; this worker is unencumbered" (Acker, 2012, p. 218). The abstract worker needs to be work oriented and thus full-time available. This worker is presented as gender neutral, but in fact resembles characteristics traditionally associated with men workers (Benschop and Doorewaard, 2012). As a result, masculine characteristics are necessary to become an ideal worker, "making it difficult for women's achievements to be recognized unless women work in masculine ways" (Lewis and Humbert, 2010, p. 242). Men are the norm, and as such, the concept of the neutral worker "excludes and marginalizes women who cannot, almost by definition, achieve the qualities of a real worker because to do so is to become like a man" (Acker, 1990, p. 150). In order to meet the standards of the abstract worker, individuals should not have too many obligations outside the workplace. Commitment to the job is required and defined in terms of behavior that indicates the primacy of work over demands of private life (Lewis and Humbert, 2010). Men are more likely to suit this image than women, since

women are in many cases still the ones who take care of the family. Employers might be reluctant to hire women for jobs in which the worker is expected to be unencumbered. Hierarchies are often gendered because "those who are committed to paid employment are 'naturally' more suited to responsibility and authority; those who must divide their commitments are in the lower ranks" (Acker, 1990, p. 149-150). Organizational logic takes material form in job descriptions, work rules and policies such as work hours, overtime, paid hours, guidelines etc. (Britton, 1997). Workers comply with these rules and principles because they view them as natural (Williams, 2012).

Although Acker's theory of gendered organizations is very helpful when studying the link between gender and organizations, using it as a tool for empirical research brings some difficulties with it. Not all organizations are gendered in the same fashion and neither does the gendering of one level of the organization mean that other levels are gendered as well (Britton, 2000). Britton, therefore, calls for a strong contextualization when studying the gendered nature of organizations (Britton, 2000). In this dissertation, I will look at the different departments as organizations in itself with different gendered substructures. Furthermore, I will make a clear distinction between different organizational aspects in order to investigate where gendering takes place and where it does not.

Another problem with Acker's theory is the failure to point out how organizational change takes place. As Wilz (2001) argues, Acker focusses on the reproduction of the gendered substructure but does not explain organizational change (Wilz, 2001). In the next section, therefore, I will present theories on structure and agency as a framework to study organizational change.

So why and how then do I use the theory of gendered organization in this dissertation? I use it in the first place to analyze the organization in which men and women operate. How do the physicians in the departments think about men and women? What image of a good doctor do they have? And which structures are in place? I will then look how the gendered substructure of the organization influences

the work of male and female physicians. Furthermore, the aim of this paper is to investigate the influence of feminization on the medical profession. The question of feminization is inextricably linked the gendered nature of the profession. Therefore, I will analyze the gendered nature of the different departments, focusing on organizational structures and cultures and see how an increase of female physicians are influenced by and in turn influence this.

2.4 Structure and Agency

The two theories on structure and agency presented here - structuration theory by Giddens (1979; 1984) and the morphological perspective (Archer, 1982; 1996) - both argue that structure establishes the context in which agents act, and that agents simultaneously shape these same structures. But they have a different view on the exact interaction between structure and agency. When I talk about structure in relation to agency, as in theories on structuration, structure means something different than organizational structure as in theories on gendered organization. Where in the latter, structure refers to a framework on which an organization is built; the former is used to designate society at large.

2.4.1 Theories of Structuration

Structuration theory as developed by Anthony Giddens (1979; 1984), proposes structure and agency as a duality: two sides of one concept. As such, Giddens tries to bridge the long going dispute between functionalism and structuralism on the one hand, and hermeneutics on the other. Where functionalists refer to structures as pre-emanating human actors, hermeneutics perceive the subjective agent to be the central focus point in social practices (Giddens 1984). The purpose of structuration theory is to

transcend this dualism between determinism and voluntarism by proposing the relationship between structure and agency as a duality (Giddens, 1984). According to Giddens, structure and agency are inseparable; an ontological unity. He states that structures do not have an independent existence but are always produced by and through agents. Structures, therewith, are not externally imposed on agents but exist in and through the activities of human actors (Den Hond, Boersma, Heres, Kroes, van Oirschot, 2012). This is exactly the point where scholars of the morphogenetic approach disagree with Giddens. They see structures as an external factor that influences the acts of agents. This is not to say that agents cannot influence and/or reproduce the existing structure, but structure can also exist apart from agential forces (Archer, 1982; 1996). Structure cannot be reduced to social action alone, although this has generated it (Archer, 1982). For Giddens, human social activities are recursive. "That is to say, they are not brought into being by social actors but continuously recreated by them via the very means whereby they express themselves *as* actors" (Giddens, 1984, p. 2). In and through their activities, agents reproduce the structural conditions that make their actions possible (Giddens, 1984). Because of the recursive nature of social actions, structuration itself is always a process and never a fixed point. As a result, structures are at all times changeable and action is always transformative. As a proponent of the morphogenetic approach, Archer (1982) criticizes Giddens on this point, arguing for action as sequential instead of recursive. Morphogenesis is a process, just like structuration, but it has an end product. As Archer explains, action is necessary for the continuation of social systems, but "the subsequent action is different from the earlier action because it is conditioned by the structural consequences of those prior actions" (Archer, 1982, p. 458). So instead of structures always being influenced by and at the same time influencing actions, some structures pre-exist action and specific agents are prior to later structural elaboration (Archer, 1996). Social transformation emerges through the interplay between agents and structure. In order to examine this interplay, Archer introduces analytical

dualism instead of Giddens proposed duality. According to her, Giddens places too much emphasis on agency and voluntarism. By conflating structure and agency, he fails to specify when there will be more voluntarism and when there will be more determinism (Archer, 2010; 1982). Because of the recursive nature of social action, Giddens never reflects the durability of constraint (Archer, 1982). For him, a change in action always means a change in structure. Giddens sees action as the transformative capacity of human agency: the actor can intervene in a series of events to alter their course. Agents always have the power to act otherwise; to say "no" (Den Hond, Boersma, Heres, Kroes, van Oirschot, 2012). "To be able to 'act otherwise', means being able to intervene in the world, or to refrain from such intervention with the effect of influencing a certain process" (Giddens, 1984, p. 14). For Giddens, the use of power is not for specific positions or modes of conduct, but involved in all actions. "All forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors" (Giddens, 1984, p. 15-16). As such, power is a transformative capacity inherent in all actions. A change in action directly leads to a change in structure. According to Archer, this is the point where Giddens fails to specify when actions result in transformation and when in replication (Archer, 1982). In the morphogenetic cycle, structures are external to agents. Structure is itself a property that stands apart from agential forces. Therefore, structures can enable but also constrain action. Social change or transformation is the product of the relative strength of agential forces on the one side, and deterministic structural forces on the other. Thus, the interplay between agency and structure is where both constraint and enablement lies. In order to see where this interplay lies exactly, degrees of freedom and constraint need to be specified and analyzed in different structural contexts and for different social groups (Archer, 1982).

2.4.2 Structure, Agency and Organizational Theory

Giddens as well as Archer use their theories on structuration to study society (Giddens, 1979; 1984; Archer, 1982; 1996). In this dissertation, though, structuration theory will be used to examine organizations. As Albano, Masino and Maggi (2010) explain, organizational theory has experienced the same division between objectivism and subjectivism as social theory has. The objectivist perspective understood structure as the prescribed framework of organizations. The subjectivist perspective, on the other hand, understood structure as interaction. Scholars within the field of organizational studies used structuration theories to reconcile the two conflicting traditional perspectives, stressing the interplay between action and structure as the source for organizational change (Albano, Masino, Maggi, 2010).

Although Archer does not refer to the discipline of organizational studies in her work on morphogenesis, she refers to the morphogenetic approach as a tool to examine the interplay between structure and agency and their outcomes in particular social formations like institutional structures and organizational forms (Archer 2010). The interplay between structure and agency can elaborate, change or reproduce a system's given form, structure or state. The social product is the outcome of the interplay between structures, cultures and agents. These outcomes can either be reproductory or transformatory, depending on the intertwining of the three (Archer, 2010). The morphogenetic approach thus refers to social systems like institutions and organizational forms, and to the reproduction or transformation of these. Therewith, it can very well be used in the analysis of organizational change.

In this dissertation, I will use structuration theory and the morphogenetic approach to examine the interplay between organizational culture, structures and the agency of male and female physicians in order to determine how the increase of female physicians has influenced medical organizations. Theories on gendered

organizations will guide in the analysis of the organizations' gendered (sub)structures.

3 Methodology

3.1 Research Question

In the discussion on the feminization of medicine, various studies suggest that an increase in female physicians will alter not only the organization of medicine, but also the content of care. Most of these studies are based on essentialist assumptions about the way men and women act. So far, no qualitative research has been conducted on how the feminization process affects medical institutions. Although a clear numerical feminization is occurring in Germany, the question remains if an increase in numbers results in structural and qualitative changes. Do women indeed work differently from their male colleagues? And do they therewith affect the content of care? As outlined in the section on gender identity, men and women act differently according to the social and cultural surroundings they inhabit. It is therefore important to look at the organization as a social context in which gender identities are constructed and reproduced, an aspect that is often neglected in the discussion on the feminization of medicine. Furthermore, women doctors do not enter a (gender)neutral profession where they can easily change the existing order by bringing in different qualities and asking for different work models. It is more likely that they come into organizations with clear structures and an already existing organizational culture. So when women enter the medical organization, what is expected of them? And how do they interact with organizational structures and cultures? In order to investigate how an increase of female physicians influences medical institutions, it is necessary to take into account how the organization functions and how it affects the way men and women

perform their job. This brings me to the following question for this dissertation: How do gender-demographic changes within the medical field influence organizational structures in the hospital and physician's medical performance?

When analyzing matters of structure and agency, it is important to specify the structural context and social groups being investigated. Therefore, I choose to do my research in three different departments of a hospital in Germany, a country that has been experiencing a feminization process over the last few years. I expected the departments to be investigated to have distinctive organizational structures and cultures, making it possible to analyze the interplay between gender, structure and agency. Through interviews with male and female physicians, I have investigated how the departments are gendered, how the feminization of medicine is encountered and how the physicians experience it affects organizational structures and the way men and women carry out their jobs. Since the feminization process is already taking place, I started my investigation by sketching the current situation and ask the doctors in retrospective how they experience the increase of female physicians has influenced their work environment. Furthermore, I have questioned them on how they work and deal with organizational structures and cultures. Theories on gendered organizations and structuration enabled me to investigate how the hospital departments are gendered.

3.2 Objective

In the last decade, a high number of women have entered medical schools and started working as physicians. In Germany, 60% of the physicians under 35 are female and there are more to come in the near future. Although some of these women will work in practices, many will end up working in the hospital, changing the composition of the physicians in many different departments. The question that arises is how this demographic shift affects the organization and practice of medicine. The

feminization of medicine has engendered a lot of opinions and predictions. It is not the aim of this dissertation to bring forth another one. Rather, the purpose is to continue the research building on the works of Kilminster et al. (2007) and Boulis and Jacobs (2008). Their suggestion is that more research is needed on how women will affect medicine, not by posing assumptions based on essentialist ideas about men and women, but through the investigation of organizational structures and their effects on the practice of medicine. So far, no qualitative research on the matter has been conducted in hospitals. Therefore, this study tries to elaborate on the discussion on the feminization of medicine by deconstructing the essentialist notions about men and women and by researching the interplay between structure and agency in different medical departments and as such gain a deeper insight in the question how women influence medicine.

3.3 Methodological Framework

The methodological approach in this dissertation consists of qualitative research methods. Literature research on gendered organizations, female physicians, and structuration theory has been used to construct a deductive research framework. In-depth, semi-structured interviews have been carried out in three different hospital departments in order to gain insight in the working structures present. Furthermore, in-depth interviews have been used to get a view on men's and women's ideas and views with regard to topics such as gendered structures, job experience and the working environment in the hospital. The collected data have first been coded and then analyzed using qualitative content analysis (Kuckartz, 2012).

3.3.1 Qualitative Analysis

In this dissertation, I use qualitative research methods as a framework for my investigation. Qualitative research methods are based on the concept of *Verstehen* (Hennink, Hutter, Bailey, 2011). Instead of aiming for an objective understanding of the issues to be investigated, *Verstehen* focuses on the experiences of the study population and the meaning they give to the topic under analysis (Hennink, Hutter, Bailey, 2011). This type of research is referred to as the interpretative approach. The interpretative approach leaves room for subjective accounts of the participant as well as the researcher. In this case, it sketches the situation of the physicians from their own perspective. The task of the interviewer is to register and interpret the meanings of what is said and how it is said (Kvale, 2007). Thus, I, as an interviewer, look at the topics under study through my analysis of the participants' perspective. Herewith, the results of the study are always mediated by not only the accounts of the participants, but also the perspective of the researcher.

Impeding the research on several different levels does not make it unusable. As Miller and Glassner (1997) argue, it should not be seen as limiting, but rather as a site for social inquiry. The presupposition that objective knowledge can be achieved through the practice of something like 'good' science is problematic anyway since it does not account for how scientific knowledge is actually made. The only way to achieve some form of objectivity is through *situated knowledges* (Haraway, 1988). Objectivity is about particular and specific embodiment and limited location. Knowledge claims that are unlocatable are rather irresponsible (Haraway, 1988). Therefore it is important to situate yourself as a researcher. Knowledge is not something that lies out there ready to be discovered but is rather produced in the interaction between subject and object. I, as a researcher, am the one who makes the knowledge claims. It is my perspective on what is being said, mediated through vision, language and culture. That is why in this dissertation I position myself as first person when I am writing. When I, as a researcher place myself not as an anonymous

objective voice, but as a historical individual, the research I do can be scrutinized (Haraway, 1988). In other words; you need to specify how your positionality affects the production of data (Harding, 1987 in Miller and Glassner, 1997).

Since my workplace is in the hospital where the department of Complementary and Integrative Medicine is situated, some of the participants already knew me as a researcher. As such, they could have been reluctant in their answers, knowing that they would probably see me again. However, none of the participants mentioned my job in the hospital as either an advantage or a difficulty.

Secondly, it is important to reflect on how my gender has influenced the research outcomes. The fact that I am a woman investigating a topic on femininity has a major effect on the research. When interviewing men and women on the sensitive topic of gender stereotypes, there is always a high risk of getting socially accepted answers. Also, the men I have interviewed might have been careful of their answers talking to a woman interviewer on the topic of femininity. Although I tried to be as open as possible, I cannot deny that my gender influenced the course and results of the interviews.

Another important factor that needs to be reflected on is language. Interviews are always mediated through and by language. The participant, who is invested in a particular position, may not hear question through same meaning frame as the interviewer (Hollway and Jefferson, 2000). This was particularly difficult in this study since German is not my mother tongue. I had to translate my interview questions to German, and the answers back to English. This translation process took not only place before and after the interview, but also during the interview. Since I conducted semi-structured interviews, I had to anticipate on the answers that the participants gave me, and pose new questions for clarification. I sometimes felt very insecure about using the right formulations. When silence fell in, I had the feeling they might not have understood me. As a result, I sometimes responded too quickly in order to make sure they comprehended my questions.

As elaborated in this paragraph, my position as a researcher has influenced this study in multiple ways. The knowledge produced in this research is the outcome of the interaction between me and the subjects under examination, all of us being situated individuals with our own ideas and perspectives.

3.3.2 Case Study

Since this study aims at analyzing the effects of the feminization of medicine on the daily work of male and female physicians, I chose to do a case study in a hospital. A case study allows the researcher to get a detailed description of situations and events and an in-depth understanding of the actors involved. More precisely, "the case method is said to be appropriate for describing, explaining, predicting or controlling processes associated with a variety of phenomena at the individual, group or organizational level" (Woodside and Wilson, 2003 in Ganon, 2010, p. 2). Focusing on three departments gave me the opportunity to move away from the surface and get a deeper understanding of the effects of feminization on an organizational level; in this case, the department of Internal and Integrative Medicine, the Breast Center and the department of Surgery.

The problem of case study research is its inability to generalize. Because the research is so specific for its context, it cannot provide general statements. Yet, it can help refine a theory or point to limits of generalizability (Ganon, 2010). It is, however, not the purpose of this research to gain generalizable outcomes. Whereas a lot has been said on the possible outcomes of the feminization process on the medical profession, no qualitative case study has been conducted in Germany on how it has manifested itself in different departments of the hospital. Therefore, in this study I focus on how feminization has been affecting the daily work of the physicians. I do, however, try to move beyond the case itself to look for general assumptions, but

always based on single cases. Doing so, I expect to be able to contribute to the current debates through the provision of new perspectives to the matter.

3.3.3 Qualitative Interviews

In this research I conducted semi-structured, in-depth interviews with male and female physicians in a German hospital. The interview questionnaire consisted out of several parts which each contained questions to a specific theme; career history, organizational structures and cultures, work-life balance and the feminization of medicine. Additionally, a research on stereotypes was part of the interview which will further be elaborated in the next paragraph. After finishing a first draft, I presented my questionnaire in several academic groups and revised the questions on the basis of the comments gained from the academic meetings before using the questionnaire in the interviews. Before starting the official interviews, I did a pretest with a physician from a unit that was not part of my study. After the pretest, I adapted and refined my interview guide to a final version (see appendix 9.1). Before starting each interview, I asked my participants to sign a letter of agreement. I then recorded the interviews with a voice recorder. The interviews lasted between 40 and 75 minutes. After each interview, I again asked my participants if they agreed with using the material gained from the interviews which all of them granted.

By using qualitative interviews as a research method, I was able to understand and document other people's understanding of the feminization of medicine (Miller and Glassner, 1997). This does not mean that I received an unmediated knowledge of the situation as it was. I think more of interviews as producing insight in the subjective experiences and perspectives of the participants. In this way, knowledge is something that is constructed in the interview process itself by both the participants and the interviewer. This makes the researcher an active contributor in the creation of knowledge since it is produced in the interaction between the interviewer and the

participant. Some scholars would see this as problematic, but Kvale (2007) argues that it is the task of the researcher to study why subjects experience and act as they do. As such, and the interviewer may even go beyond the subjects self-understanding by interpreting and questioning the accounts of the participants (Kvale, 2007). Herewith, qualitative research, and qualitative interviews in specific, are always mediated and based on interpretation, on the side of the interviewer as well as on the side of the participant. Neither selves (participant telling like it is) nor accounts (researcher) are transparent (Hollway and Jefferson, 2000). This leaves us with the problem of validity. But although interviews are never a mirror reflection of objective knowledge, they do provide access to the meanings people attribute to their experiences and social worlds. Furthermore, interviews can provide knowledge about the social world beyond the interview itself (Miller and Glassner, 1997).

3.3.4 Research on Stereotypes

In this dissertation, I will use research on stereotypes to find out what stereotypical ideas exist on men and women and how these relate to ideas about a good doctor and a good chief physician. There are many ways to conceptualize stereotypes. The definition given by Ashmore and Delboca is most useful for this research. They define stereotypes as "a set of beliefs about the personal attributes of a group of people" (Ashmore and DelBoca, 1981). For this dissertation, I am interested in gender stereotypes in particular. In the 1970's, a method was developed by Sandra Bem to identify gender stereotypes in organizations, called the Bem Sex Role Inventory (BSRI) (Bem, 1974). She herself defines her theory as "a new sex role inventory that treats masculinity and femininity as two independent dimensions, thereby making it possible to characterize a person as masculine or feminine or androgynous as a function of the difference between his or her endorsement of masculine and feminine personality characteristics" (Bem, 1974, p. 155). The problem with Bem's sex role

inventory is that the traits are already characterized as being either male or female or androgynous, leaving no room for a person's own interpretation of what is masculine or feminine. Since my aim with this research is to find out the physicians' perspective on masculine and feminine traits in general and in relation to their image of a good doctor, I used a tool developed by Gmür called the KGMI (Gmür, 2006). In his research on gender and managers, he used a list of 30 attributes compiled from various sources and categorized them as masculine, feminine or gender-neutral. He then asked his sample to identify the traits as either more masculine or more feminine (Gmür, 2006). For my study, I used ten attributes from his list, reducing myself to ones that I considered relevant for the medical profession (see appendix 9.2). I first asked my participants if they found this specific attribute important or not important for a good doctor and for a chief physician. I then used the same list to ask them if they saw the trait as more masculine or more feminine. As such, I was able to find out which stereotypes are present in the departments and how these relate to beliefs about a good doctor.

3.3.6 Sampling

The interviews have been conducted in three different departments of a hospital in the Ruhr district in Germany. The hospital was established in 1995 when two already renowned hospitals consolidated into one clinic. The hospital has 696 beds distributed over 12 specialist departments. The study took place in three of these units: the department of Internal and Integrative Medicine, the Breast Center and the department of Surgery. There are a few reasons why I chose to study these three departments in this dissertation. When investigating the influence of female physicians on the medical institution, it is impossible to speak of medicine or the hospital as a homogenous field since the effects will differ with regard to different organizational contexts. Therefore, I chose to study three hospital departments that

were likely to differ in their organizational structure and culture and as such investigate the distinct effects of the feminization process on medical institutions. This has off course not allowed me to grasp the heterogeneous nature of medicine at large. On the contrary; it has only given me partial insight in the influence of feminization on the medical profession. Nevertheless, it has given me the opportunity to focus on possible differences with regard to how the feminization process has affected the profession. Furthermore, when examining the interplay between structure and agency, it is important to specify distinct structural contexts and social groups. Therefore, I conducted my study in different organizational environments and decided to interview men as well as women. Taking departments that differ in their organizational structures and culture as a sample allowed me to reflect on the multiple ways in which the feminization process affects the medical world.

Complementary and alternative medicine (CAM) is usually seen as a very feminine specialty where most practitioners and users are women (Cant and Watts, 2012). A research conducted among medical students in Germany showed that female students are still more pulled toward CAM than their male counterparts (Sarah Vader, 2012). Women are drawn to practice alternative medicine because of its caring, nurturing and preventive focus (Cant and Watts 2012: 488). Conducting the research in this unit has a major influence on the outcome of this study. Not only because it is a "feminine" medical field with many female employees, but also because it has a different view on medical practices in general. It is therefore possible that the physicians experience the feminization of medicine very differently from doctors in the department of Surgery, which is perceived as a very masculine field where women are scarcely allowed and only if they comply and accommodate to the masculine system (Halford and Leonard, 2001; Lange, 2013). A study done in Norway and Sweden shows that the closed male world of surgery forms more than an obstacle to women than does their own capacity to do the work. "Definitions of what counts as success are not self-evident but socially constructed. The power of the

surgeons rests on their discursive strategies for enforcing their definition of the character and status of their work" (Riska, 2001, p. 181). In the Breast Center, breast cancer patients are treated with integrative medicine therapies; a combination of alternative and regular treatment. Herewith, it is placed between the department of Internal and Integrative Medicine on the one hand and Surgery on the other.

I purposively chose these very different departments to investigate the diverse effects of the feminization of medicine on the one hand, and the influence of distinct organizational structures and cultures on the experience of the feminization process and the practice of medicine on the other. The questions studied with regard to these different sectors were how the departments are gendered, what the differences in the composition of the departments are, which positions men and women have, how the physicians experience the feminization of medicine and what influence all of this has on the organizational structures and practice of medicine?

In order to gain access to a suitable sample for my research, I approached the heads of the departments and asked if they would allow me to do a study in their organization. After permission, I introduced the theme of my dissertation during the staff meetings of the selected departments and asked for volunteers to participate. Thereafter, the physicians who wanted to participate contacted me by telephone or email. Out of the replies, I selected men as well as women holding positions that ranged from assistant physician to chief physician in order to cover a broad spectrum of job positions. Physicians who were still in their preliminary medical examination phase or their practical year were excluded from this sample as was the non-medical staff working in the department. I decided to interview men as well as women, since both genders are affected by the feminization process and because both sexes need to be taken into account in the analysis of gendered organizations. In the Surgery department, I interviewed two men and six women. In the Internal and Integrative department as well as in the Breast Center, three men and five women took part in the interviews (see appendix 9.3).

All the interviewees have signed an official agreement of part-taking in the interviews and agreed to the included terms and conditions. In order to safeguard the highest achievable level anonymity of my participants, I used randomly chosen alias names in the draw up of the interviews.

3.4 Analytical Framework

The interviews have been transcribed by a professional transcription office and transcribed verbatim in order to make them useable for analysis. Literature research on the feminization of medicine and gendered organizations have been used as a theoretical background and to construct a deductive research framework. Qualitative Content Analysis (Kracauer, 1952; Mayring, 2010; Kuckarz, 2012) has been used as a framework in the analysis of the interviews and the literature.

3.4.1 Qualitative Content Analysis

Qualitative Content Analysis has been introduced by Kracauer in 1952 and was later developed by Mayring (2010) as a tool to classify and categorize interview material. It is a form of assessment in which *Verstehen* and the interpretation of interview material play a central role (Kuckarz, 2012).

Qualitative Content Analysis can be used in different forms. One of these forms is the directed approach which is used to validate or conceptually extent an existing research (Fang and Shannon, 2012). Because of the extensive amount of literature on the feminization of medicine, this approach seemed most suitable as an analytical method for my study. The directed approach also has its difficulties. Using theory as a guideline in the analysis of the interviews has some inherent limitations in that researchers approach the data with an informed and therewith biased opinion. "Hence, researchers might be more likely to find evidence that is supportive rather

than nonsupportive of a theory" (Fang and Shannon, 2012, p. 1283). In order to prevent myself from falling in this trap, I not only used a deductive code scheme, but also used inductive codes that came out of the interview material itself. After the transcriptions of the interviews had been completed, I started the coding process using MAXQDA. I started with deductive codes that I created out of the literature and the interview guide. Although these categories give a good oversight of the different themes that are discussed in the interviews, they do not allow grasping the uniqueness of every interview. In order to get a deeper insight in the physicians' statements and as such create an image of the person behind the announcements, I read the interviews several times and developed inductive codes from the data itself (see appendix 10.4). After finishing the coding, I analyzed the interviews on a horizontal and vertical level (Kuckarz, 2012). On the vertical level, I took the participant as the central object for analysis. On the horizontal level, I took a theme - for example feminization - as a starting point and tried to find differences and commonalities between the participants. As such, I was able to make a thorough analysis of the distinct individuals but also to move away from the single persons and look for generalizability.

During the process of analysis, I presented and discussed the outcomes of my research in several academic research groups like the Essener Kolleg für Geschlechterforschung, the academic colloquium of Prof. Ute Klammer and a research group as part of the master degree in Social Work at the University of Duisburg-Essen. As such, I was able to reflect and enhance my work in accordance with commentaries gained out of these academic meetings.

4 Results

In this section, the outcomes of the interviews will be presented and discussed. First, the functioning of the organization will be portrayed by means of the interviews with a special focus on its culture and structure and the interrelation of these two. As outlined in the section on gendered organizations, men and women who enter medical institutions do not face gender-neutral workplaces, but come to work in departments with a certain culture, structure and (un)described rules that determine how men and women should perform their job. What are these rules? What ideas exist on proper work? What image of a good doctor is prevalent? What stereotypes come about and how does that affect medical practices? After having discussed these questions, I will describe how the physicians experience the feminization of medicine and what they expect it to bring forth. I will then elaborate on the interplay between structure and agency and look at how the feminization process has actually affected the three departments. Do women indeed have different qualities from men? Do they bring a distinct component to medicine? And how does this relate to the structural side of the profession? These issues will be discussed in the next paragraphs, in which I will analyze in detail how the feminization process has affected the departments of Surgery, the Alternative and Integrative Medicine department and the Breast Center.

4.1 Department of Surgery and Center for Minimal Invasive Surgery

Traditionally, surgery has been a male dominated profession with strong hierarchical structures, long working hours and only few female workers (Riska, 2001). A study conducted in five OECD countries showed that although women have become highly involved in specialties such as general medicine and pediatrics, their

part-taking in surgery remains low (Riska, 2001). Even though surgery remains more masculine dominated in comparison to other specialties, the number of women physicians in the domain has increased in the last years. In 2014, Germany counted 18% of its surgeons female ("Feminisierung der Medizin", 2014) compared to approximately 13% in the year 2000 (Wagler, 2005). This numerical augmentation is also visible in the department of Surgery and Center for Minimal Invasive Surgery where only eight of the twenty physicians in the department are female, but six out of eight assistant physicians are women; a significant majority.

The department of Surgery and Center for Minimal Invasive Surgery in its current form was started in 1999 when Mr. Schneider became the department's chief physician. The center is specialized in minimal and invasive surgical interventions. The department has three operation theatres and a total of 56 beds spread over four wards. In addition to three regular wards, the department has a separate ward for private patients.

Although the hospital in which the department is situated is an academic education hospital, it is not a university clinic with extraordinary work hours. According to Mr. Schneider, this is especially noticeable during nightshifts when, in comparison to a university hospital, hardly any operations take place. But even though the work hours in the department are not as excessive as in a university clinic, the department of Surgery knows a culture and organizational structure where extra hours are a self-evidential part of being a surgeon. As the next sections elaborate, work hours in the department are long and gravely influence on the surgeons' design of their private lives.

4.1.1 Organizational Culture and Structures

Mr. Schneider, the head of department, has been chief since 1999. According to him, the field of surgery has not experienced major changes over the last years. The

same goes for his department. When Mr. Schneider became chief physician, he took over the already existing procedures because they proved to be successful. Therewith, the operational procedures and work structures in the organization have not changed much. The department of Surgery is structured in such a manner that operations take place every day. An operation plan is made in advance to determine which physicians perform the operations. Who performs and assists is decided by the chief and leading senior physician. A strict hierarchy is present when it comes to surgical operations. The senior physicians get appointed the big and interesting ones and the assistants the smaller ones.

> „Die großen Operationen sind natürlich für die Oberärzte. Ich bin noch junge Assistenzärztin, bin jetzt im dritten Jahr, und das_ Ich mache das, was für meinen Ausbildungszeitpunkt eben notwendig ist. Ich kann also auch nicht erwarten, dass ich jetzt eine Magenresektion machen muss, wo ich absolut noch nicht bereit dafür bin. Das lerne ich alles nach und nach, und ich kann mich nicht beschweren." (Ms. Mohr)

In addition to performing surgery, the physicians visit patients, have consultation hours and run the wards. The work hours in the department are long. For the assistant and senior physicians, workdays start at 7 AM and finish somewhere between 6 and 7 PM. As Ms. Toman elaborates, there is a strong difference between formal work hours and the actual amount of hours the physicians spend at work.

> „Ja, die offizielle Arbeitszeit ist ja schon 7 Uhr Beginn, und normalerweise, meine ich, Viertel nach Vier, mit 45 min. Pause, ist dann Schluss. Nur: Das ist nie der Fall_ also, ich würde sagen, fast nie der Fall. Das heißt, wir fangen um Sieben an. Wobei ich noch früher da bin, also, man ist dann schon so um 20 vor Sieben oder so hier. Und man kommt so, also, sagen wir einmal, wenn man Glück hat, kommt man so zwisch_ also, auf dieser Station so zwischen 18, 18 Uhr und 18.30 Uhr raus. Das ist so die_ Also, es gibt auch Tage, wo wir dann länger bleiben, weil wir dann alle im OP sind und auf der Station nicht so viel gemacht wurde, dann kommen alle raus und müssen dann die

Station noch fertig machen, dann bleibt man auch einmal länger. Aber so bis_ zwischen 18 und 18.30 Uhr, das ist eine völlig normale Zeit." (Ms. Toman)

The other physicians in the department also refer to the many extra hours they spend at work and the officially appointed breaks they hardly ever get. There are official rules that, according to Mr. Peper, *off course* are not met. The implicitness with which Mr. Peper refers to this phenomenon characterizes the normality of extra hours and the perception of work as more important than personal necessities such as breaks.

„Es gab ja diese EU-Regelung mit Arbeitszeit und Schutzzeiten und Ruhezeiten. Es gibt ja eigentlich formal vom Gesetzgeber strenge Vorgaben, und formal genügen wir diesen Vorgaben, indem, glaube ich, eine Mittagspause von 1 ½ Stunden sozusagen vorgesehen ist, die natürlich in der Praxis nie erfolgt." (Mr. Peper)

Mr. Schneider acknowledges that his employees work more hours than they are formally appointed to, but in his opinion, this is an inevitable aspect of being a surgeon. He always worked more or less 12 hours a day and thus this appears normal to him. He also rectifies the many hours his employees have to be at work with the statement that he has never heard feedback from his physicians that they are unsatisfied with their work hours.

„Vielleicht kann man sagen, dass nicht alle Mitarbeiter jetzt immer bis 20 Uhr arbeiten hier, so, aber viele arbeiten, glaube ich, länger als sie müssten, und, ich glaube, ihnen macht das_ Also, es gibt kein Feedback, dass ihnen das nicht passt. Ja, ich erwarte natürlich auch eine gewisse Arbeitsintensität, aber es gibt auch etwas dafür, auch klar. Und insofern haben sich an den Arbeitsabläufen wenig geändert." (Mr. Schneider)

Mr. Schneider explains that although work hours are long, the physicians also get something in return namely many hours of surgical experience which is an important factor in the surgeons' specialist training. He sees the long work hours of his

employees as an investment in their training. Ms. Ott emphasizes Mr. Schneider's statement explaining how surgery is a specialty where many flight hours are necessary in order to master the profession. It is not that you see how an appendix needs to be operated and then you can do it yourself. You need to practice over and over again in order to become a good surgeon.

> „Also, insbesondere chirurgisch muss man viel, viel, viel machen, um es einfach zu lernen, dieses Fach an sich. Also, ich glaube, man muss nicht lernen, mit dem Patienten umzugehen oder eine Diagnose zu stellen oder zu entscheiden, ob der Mann oder die Frau operiert werden muss oder nicht. Aber allein diese Operation an sich! Wenn man einen Blinddarm operiert hat, kann man nicht operieren! Das muss man zehn Mal gemacht haben! Und man muss es vielleicht auch zehn Mal gesehen haben vorneweg. Und das ist ja_ Das ist einfach ein Zeitfaktor."(Ms. Ott)

As this excerpt highlights, assistant surgeons have to spend many hours in the operation theatre in order to learn the skills of surgery. Since the chief and senior physicians decide who can perform the operations, the assistant physicians are dependent on their seniors in the progression of their training.

Although over the years, the organizational structures of the surgery department have hardly changed, the workload has slowly increased. Extra hours have always been part and parcel of the profession, but the amount of work that the physicians need to carry is becoming more whereas the number of physicians who execute the work remain the same, increasing the work pressure on the surgeons.

> „Also, es war immer schon so, dass die Arbeitsbelastung hoch war, aber ich habe immer das Gefühl, es wird noch ein bisschen mehr und noch ein bisschen mehr. Und man sieht das ja auch an den Zahlen, es werden halt jedes Jahr wieder noch einmal 50 Patienten mehr. Also, es sind keine großen Sprünge, aber es ist trotzdem, es ist irgendwie ein stetiges Wachstum, und das aber eigentlich mit der immer gleich bleibenden Zahl an Mitarbeitern und auch Pfleger auf Station und Betten und so. Also,

> es ist schon eine steigende Belastung. […] Also, wir haben ja ursprünglich nur mit zwei Operationssälen operiert, jetzt haben wir mittlerweile drei, an manchen Tagen sogar vier, […] " (Mr. Peper)

With a growth in the number of patients over the last years, work hours have become more. For the physicians in the department this is an important item. Although the chief of the department thinks his employees are satisfied with their work time, the doctors in fact complain about the high number of hours they have to spend at work. As elaborated in the next section, almost all physicians show dissatisfaction when it comes to their work hours and the little room this leaves for their private necessities.

4.1.1.1 Work-Life Balance

The high amount of hours the physicians of the Surgery department spend at work have a significant effect on their private lives. In many cases, work takes up so much space that there is hardly any room left for a private life. Most of the physicians I interviewed are single stating that their current work hours make it impossible for them to have a relationship, let alone a family. According to Ms. Toman, this is nothing unusual in surgery. It is especially the female physicians in the department who consider it difficult to reconcile their work and family life. Most of them cannot even imagine having a relationship due to the simple fact that they do not have time for that. Neither can they find the time to regularly see friends and family or to go to the gym.

> „Ja, ich bin ledig und ohne Freund. […] Und ohne Kinder, Katze und/oder irgendwas. Weil, das wäre zeitlich nicht vereinbar, ganz klar." (Ms. Ott)

Just like Ms. Ott, Ms. Adler dedicates de incompatibility of work and private life to the many hours she has to spend at work. She explains that she would like to have more room for personal matters, but that her work hours do not let her.

> „Ja, das würde nicht gehen. Also, ich hätte z. B. gern ein Haustier, einen Hund oder so. Aber das geht ja nicht, wenn man zwölf Stunden am Tag_" (Ms. Adler)

Mr. Peper does have a family but his wife is the main caretaker of their four children. His wife used to work full-time in a radiology department but gave up her work to take care of the family. Mr. Peper is fully occupied with his work in the clinic and a few hours with the children every day and has no time left for other private matters or hobbies. As he explains, there is no such thing as a work-life balance with a full-time job and a family to take care of.

> „Kombinieren? Äh, geht eigentlich gar nicht so richtig, ehrlich gesagt. Also, man hat ja hier wirklich einen Fulltime-Job, d. h., man ist dann auch abends eben mit der Familie dann dabei, sozusagen. Bis die Kinder dann im Bett sind ist ja dann auch irgendwie neun Uhr, und dann ist eigentlich wenig Zeit noch für irgendwelche Hobbys dann abends. Also, da fehlt mir auch persönlich die Energie." (Mr. Peper)

Mr. Peper clearly states that combining a full-time job in the hospital cannot be combined with a well-balanced personal life. His job thus takes on a central place in his life and determines the extent of his personal life. The same goes for most of the other surgeons in the department. The long workdays strongly influence the design of their private lives. The interviews sketch how work dictates private life, not the other way around. Ms. Bluhm underlines this mechanism when she states that private life does not start until work is finished which does not leave much room for leisure time.

„Na ja, ich meine, Freizeit beginnt dann, wenn die Arbeit hier zu Ende ist. Und wenn man dann nicht total müde ist, also, eigentlich ich_ Man_ Man ist ja auch ein bisschen trainiert." (Ms. Bluhm)

Ms. Bluhm's statement shows how personal necessities have no room at all in the daily work life of the physicians in the Surgery department. Work not only takes on a central place, but private needs also need to be pushed aside and can only relive once all work is finished. Many physicians refer to the fact that once they come home, they are too tired to really undertake something for themselves. This leads to dissatisfaction. Although the physicians in the department like their work, they are unsatisfied with the amount of space work takes in their lives. Mr. Peper expresses his discontent with regard to his work hours stating that reducing the physicians work hours would have a positive effect the surgeons' lives.

„Also, da bin ich schon unzufrieden, grundsätzlich, muss ich schon sagen. Also, da_ oder, es wäre verbesserungswürdig, sagen wir einmal so. Es gäbe schon viele Optionen, einfach, wenn man sagt, wenn man jetzt jeden Tag wirklich pünktlich um 16.30 Uhr Feierabend hätte, glaube ich, dass das schon sehr positiv sich auswirken würde für das Familienleben oder eventuelle Hobbys, weil man dann einfach einmal Sachen machen kann, wie einfach einmal einkaufen gehen oder so, was einem jetzt so im Alltag irgendwie komplett fehlt. […] Ich weiß gar nicht, wann ich das letzte Mal irgendwie ganz normal Lebens-mittel einkaufen war oder so. Also, es ist wirklich so etwas ganz Banales, kommt man irgendwie schon kaum mehr zu. Oder auch einmal irgendwie nur so einfache Termine auf dem Amt oder bei der Post oder irgendwie so etwas, das klappt schon eigentlich kaum mehr im normalen Alltag. Also, Arbeitszeiten, das wäre sicherlich etwas, was verbesserungswürdig wäre." (Mr. Peper)

The excerpt above shows the grave effect of overtime on Mr. Peper's personal life. He states that he cannot remember when he went grocery shopping or to the post office. These things are scarcely possible because of the long days he spends at the hospital.

Mr. Peper is not the only doctor in the department who is unsatisfied with his work hours. All of the physicians I interviewed, with exception of the chief, have shown discontent when it comes to overtime and work-life balance. They complain about the long workdays, the little room there is left for private life and how over hours are not even paid.

> „Also, wenn ich jetzt eine_ Also, sagen wir einmal (lacht)_ wenn ich sagen würde, 1 ist ‚sehr gut' und 10 ist ‚sehr schlecht', würde ich sagen, bin ich bei 8. Also, eigentlich bin ich nicht zufrieden, weil, man arbeitet viel zu viel, also, und unbezahlt halt, 'ne. Also, das sind ja einfach so_ Zeit, die man hier arbeitet, wo man weiß, dafür kriegt man nichts. Und das sind jeden Tag mindestens drei Stunden, drei bis vier. Und das läppert sich ja alles, und wenn man dann überlegt_ gut, man kriegt noch nicht einmal dann eine Entschädigung dafür oder Freizeitausgleich, dass man sagt, ‚Gut, jetzt waren Sie halt irgendwie so lange hier, dann nehmen Sie sich zwei Wochen frei' oder so, das ist ja auch nicht der Fall. Und bezahlt kriegt man das auch nicht, also, so dass man schon manchmal denkt_ Ja, man macht Vieles halt einfach auch umsonst, 'ne." (Ms. Toman)

Ms. Toman, for example, complains about the extensive workload. But she seems most dissatisfied with the fact that the time and effort she and the other physicians put in their work are not balanced out with for example money or leisure time. The huge sacrifices the surgeons make are not seen or acknowledged and therefore not rewarded either. This seems to be Ms. Toman's biggest frustration.

Ms. Ott also shows discontent when it comes to her workload. She even states that this way of living is only a phase in her life that she is not willing to continue for much longer. Her dissatisfaction thus is so big, that it could possibly end in a termination of her job in the department.

> „Das ist die Phase, und ich bin ganz schwer davon überzeugt, dass ich schon das nicht so auf dauer machen möchte." (Ms. Ott)

Ms. Bluhm also states that she only wants to have such an intensive work life for a certain amount of time.

> „(lacht) Also, das kann man einmal für eine gewisse Zeit machen, ja. Zufrieden kann keiner damit sein. Also, ich kann_ Ich bin nicht damit zufrieden, wenn ich morgens um Viertel vor Sieben hier bin und abends um Sieben bzw. halb Acht hier wieder rauskomme. Das ist auch für mich nicht mein Ziel, was ich irgendwie in meinem Leben irgendwie habe, dass ich irgendwie nur mich um den Beruf kümmere, irgendwie mein Leben lang." (Ms. Bluhm)

Although the surgeons are dissatisfied with their workload on the one hand, on the other, there is a level of understanding and even acceptance of their work hours. They see overtime as an inevitable part of their job. Ms. Mohr explains how she has accepted the fact that extra hours come with the job. In her training years, she regularly stayed until 7 or 8 PM, and thus, she states: "Ich habe es akzeptiert, ich wusste, was auf mich zukommt, ich wusste es von vornherein." Here, Ms. Mohr uses the element of knowing in advance what to expect as a legitimization for overtime. Ms. Toman, who explicitly expresses her dissatisfaction with the large amount of work hours, also explains that long work hours are an unavoidable part of being a surgeon.

> „Na ja, der Beruf steht halt ganz oben, 'ne, also, automatisch, weil man halt die meiste Zeit einfach hier ist. Also, selbst wenn man versuchte, dann gut, heute hast du einen Termin, heute <u>musst</u> du das und das machen. Aber teilweise klappt es einfach nicht, weil_ Ich kann dann auch nicht einfach gehen, weil man dann denkt, es sind ja halt irgendwo auch „Menschen, 'ne, die man dann halt in der Betreuung hat, es sind ja jetzt nicht irgendwie Maschinen, die man abstellen kann, oder Büroarbeit, wo man sagt, ‚Komm, lass' liegen, geh!' Also, das ist schon_ […]" (Ms. Toman)

Ms. Toman explains how being a physician means you work with patients, not machines you can just shut down. She distinguishes care work from other jobs where you can just leave the work to be done for the next day. It is the doctors' responsibility to provide patients with the needed care which gives them a certain degree of irreplaceability. Ms. Toman says that sometimes private appointments cannot be met because work needs to be finished first. This excerpt again emphasizes the importance of work over private matters; personal necessities cannot obstruct the provision of care.

Where Ms. Toman brings forth the work with patients as a reason for the extra hours the surgeons spend at work, Mr. Peper has a different explanation for the long hours.

> „Ah ja, im meine, letztlich ist man natürlich auch freiwillig auch hier. Ich meine, klar kann man auch um_ könnte man theoretisch sagen, um 16.30 Uhr, ‚So, tschüss, es gibt einen Diensthabenden, alle Anfragen bitte an den Diensthabenden', Telefon ausmachen und fertig. Aber letztlich ist das ja auch hier so eine Art Mannschaftssport, 'ne, ist ja so. Wir sind ja ein Team, und man unterstützt sich natürlich, wo man kann. Das wird einem irgendwie auch eine Art von Befriedigung verschaffen, sonst würde man es nicht machen. Sonst würde man ja genauso agieren, dass man sagt, man geht jetzt nach Hause und lass die anderen machen, die werden dafür bezahlt. Aber ich denke, so hilft man schon irgendwie den anderen, und es wird einem ja auch dann geholfen, wenn man selbst in der Situation ist, dass man noch im OP steht und dann freut man sich auch, wenn noch irgendjemand da ist, der einen da irgendwie unterstützt. Oder dann eben auch dann spät am Nachmittag noch die OP-Pläne für den nächsten Tag fertig machen oder, oder. Das hilft auch immer, wenn man da mit einem Paar Augen mehr drüber guckt. Und ich denke, das ist so ein bisschen die Motivation, dass einfach so die Mannschaft und so, das Gemeinschaftsgefühl, letztlich, was man hier bei der Arbeit auch hat. Sonst würde man das, glaube ich, nicht ertragen. (lacht)." (Mr. Peper)

Mr. Peper explains that theoretically speaking, you could go home when your shift is finished and leave the work to be done for the physicians on duty. But it is more satisfying if you help your colleagues and it also means that they help you out when you are in need. The motivation behind staying until the job is done is the teamwork; the feeling of fixing the job together. Teamwork and patient care are thus used by the physicians to rationalize and normalize the impeding of work on their private lives. The physicians are dissatisfied with the time and energy work takes up. Some even state that the high workload is only bearable for a certain amount of time. But on the other hand, they see it as an inevitable factor of their profession. They *need* to be there because their patients or their colleagues need them. This is used as an explanation for the impossibility to keep the contracted work hours and suits as a justification for overtime. Mr. Peper also affirms the voluntary part of the job. So although he complains about the long workdays on the one hand, he balances this out by stating that the surgeons also have a choice. That choice though, is not completely free due to the expectations of patients and colleagues.

4.1.1.2 Part-Time Work

As has become clear in the section on organizational structures, most of the physicians I interviewed would like to reduce their work hours. According to the chief of the department, part-time work should not be problematic as long as emergency training and night and weekend shifts are complied with.

> „Das Problem ist bei Teilzeit auch natürlich, dass Dienstbereitschaft schon mit notwendig ist vielleicht auch sogar, denn Dienste heißt Notfall, und Notfalltraining und Notfallkenntnisse muss man natürlich haben, und, also, es muss dann schon möglich sein, selbst wenn man teilzeitarbeitet, dass man auch im Dienst tätig ist, aber wir haben das auch zurzeit so." (Mr. Schneider)

Mr. Peper also believes in the possibilities of part-time work. Especially after having worked for a significant number of years, physicians can justly work part-time. The example he gives, though, is an hour reduction of 10%.

> […] eigentlich ist es_ müsste es machbar sein, glaube ich. Auch, wenn man sagt, irgendwann, ‚So, ich habe jetzt 15 Jahre hier Vollzeit gearbeitet, ich habe meine ganzen Facharzttitel, ich habe_ ich bin nicht mehr in der Pflicht, irgendwie ganz viele Operationen machen zu müssen, sondern ich will doch irgendwie den Schwerpunkt verschieben, gibt es sicherlich Modelle, wo man sagt, man macht z. B. eine 90%-Stelle oder so. Das klingt gar nicht großartig verändert, man kann auch ganz normal seine Arbeit machen, aber man hätte dann in so einer Konstellation z. B. 20 Urlaubstage mehr pro Jahr. D. h., man könnte dann mit den Kindern zumindest schön in die Sommerferien fahren und vielleicht ein bisschen mehr von dieser Feriengestaltung oder so machen. (Mr. Peper)

A 90%- job, as Mr. Peper suggests, results in a few days of extra leave. This way, the reduced hours do not affect the doctor's working day so "you can normally do your work". This proposal fosters the image of the abstract worker who is completely focused on the job and has no obligations outside the workplace. Mr. Peper explains that part-time work is possible, but only if it does not affect the physician's daily work which emphasizes the normality of long hours work and the necessity of being present on the work floor.

Although the chief of the department refers to the possibility of part-time work his employees do not see this easily accomplished. Ms. Toman explains that she sees the reduction of work hours within the department as impossible. The only likely occasion is when a woman has children. Otherwise, part-time work it is neither possible, nor accepted.

> Also, was man machen kann natürlich, dass man sagt, ‚Gut, ich reduziere die Stelle. Ich mache keine Vollzeitstelle, sondern mache nur eine 80- oder 75-' Aber das ist auch in

> der Klinik nicht möglich, also, d. h. das machen halt bei uns wirklich_ also, macht jetzt jemand, der halt ein Kind hat, der kann sich aber so_ Das wird auch, glaube ich, gar nicht akzeptiert werden, dass man sagt, ‚So, ja, ich möchte jetzt gern 80 %', und die Frage kommt: Warum, wieso, weshalb? (Ms. Toman)

Ms. Bluhm shares this opinion, stating that the only chance on reducing work hours is to be extremely tough and persevere.

> Ja, man kann eine Stelle reduzieren, 'ne, das kann man schon machen. Aber es ist auch nicht so_ ganz so einfach, glaube ich, auf so einem_ Also, man muss das dann schon sehr ha_ knallhart auch irgendwie durchziehen und sagen, ‚Okay, ich habe jetzt was weiß ich eine 60- oder 70-%-Stelle und um 14 Uhr endet mein Arbeitstag und dann bin ich auch weg'. Weil, es wird ja gerade in diesem Beruf auch immer erwartet, dass wir halt einfach da sind und auch über unsere Arbeitszeit hinaus natürlich noch für Patienten und Krankenhaus und alle da sind, so (Ms. Bluhm)

Ms. Bluhm states that if the doctors want to reduce their hours, they have to show perseverance because it is expected that physicians are there for the patients and the hospital. Thus although theoretically speaking part-time work in the department is possible, the actual options are scarce and the organization's culture where long work hours and complaisance are important virtues does not contribute to the creation of part-time work opportunities.

Another causing factor in the difficulty of part-time work is the construction of specialist training. Surgeons in training need to have an extensive amount of hours of practice. Interrupting the training makes it difficult to reenter because those doctors who drop out for a certain amount of time have to queue up again. Part-time training also has its difficulties. According to Mr. Peper, an hour reduction of 20% should be compatible with specialist training but a further cutback could have implications for

the obtainment of a specialist degree. Mr. Schneider sees the interruption of specialist training as problematic as well.

> Inwieweit die Kontinuität in der Ausbildung unterbrochen wird, kann ich mir vorstellen, dass das schwierig ist, einen Wiedereinstieg zu kriegen. Also, wenn Sie über Jahre hin den Job nicht gemacht haben, fangen Sie nicht bei Null an, aber Sie fangen_ Sie müssen sich hinten einreihen. Wenn Sie Unterbrechungen haben, dann müssen Sie sich hinten einreihen. (Mr. Schneider)

The difficulties surrounding the reentrance of specialist training is especially problematic for women since the years of specialist training often coincide with those of family founding, making it unfavorable for women to start a family before finishing their training. This is a clear example of how organizational structures that seem gender neutral affect women differently from men. The men in the department who have a family also have a wife at home who takes care of the children so that they can pursue their career. The female physicians who want to have a family have to interrupt their work for several months or years, resulting in difficulties when it comes to reentering the training.

With regard to the reduction of work hours and part-time jobs, the rhetoric about the possibilities is stronger than the actual options. And even when actual possibilities are there, a culture of long work hours argues against this. These organizing processes affect women differently from men. For women who are forced to leave the workplace during pregnancy and the first months after childbirth and who in many cases are still responsible for caring work at home, it is more difficult to combine work and family than for men.

4.1.3 The Feminization Process in the Surgery Department

Because surgery has always been a strong masculine domain, it was not until recently that women numerously entered the profession ("Feminisierung der Medizin", 2014). Times have changed and surgery is no longer accessible to men only. Mr. Schneider, who has been in the profession for over 30 years, explains that back in the days, women used to be the exception in surgery. But this has changed gravely over the last years with more and more women entering the profession. Nowadays, female surgeons have become a matter of course.

> „Na ja, das ist ja ganz einfach. Also, vor 30 Jahren gab es 3 % Chirurginnen, ja? Vor 15 Jahren waren es 10 % und heute sind es 50, 6 %. Also, d. h. wir haben einen ganz enormen Shift. Damals waren_ In der Anfangsphase waren die Frauen in der Chirurgie Exoten, man hat sich gewundert, was sie da wollen, und inzwischen ist das ja völlig anders. Ist ja eine Selbstverständlichkeit geworden." (Mr. Schneider)

As Mr. Schneider explains, women used to be a rarity in surgery. It was something that men did. Ms. Toman also refers to surgery as a typical male domain that used to be a no-go area for women.

> „Weil, früher war die Chirurgie ja immer absolutes No-go für eine Frau, heute ist total, ist das ja fast_ fast normal. Und bei uns machen halt, also, so, wenn wir jetzt so die PJ'ler und so, also, die Studenten, die hier mal sind, also, sind auch mehr so_ mehr_ sind sowieso immer mehr Frauen da. Und die Männer sind mehr so für Unfallchirurgie und Orthopädie, und Frauen sind mehr so, ja, entweder Internisten, Pediater oder, wenn Chirurgie, dann so die allgemeine Chirurgie. Also, das hat schon, würde ich sagen, zugenommen. […] Weil, früher hat man einfach gesagt, ‚Ja, aber die Chirurgie ist z. B._' oder ‚Es ist einfach so eine Männerdomäne', und ‚Da kommst du nie rein und da wirst du_ da wird aus dir auch nie etwas!'. So. Und ich glaube, das haben einfach Viele gemerkt, dass es nicht so ist. Ja, und dass man halt einfach auch in der Chirurgie gut

> Karriere machen können, und weil man hat hier Frauen ja auch immer so verbunden mit Pädiatrie und Innere so, ja, also, das sind so Sachen, die die Frauen machen können. Aber das hat sich ja mittlerweile alles geändert." (Ms Toman)

The excerpts above sketch an image of surgery as a job that women were not able to advance in because traditional feminine characteristics did not match the image of a surgeon. As such, the domain of surgery remained closed for women. Ms. Toman explains that it is due to the increase of female physicians in not only medicine in general, but also in surgery that the idea that women cannot be good surgeons has changed. In the next paragraph, I will elaborate if the increase of female physicians has also changed surgery?

4.1.3.1 Feminization of Structure

The discussion on the feminization of medicine proposes that the increase in women doctors will alter the profession`s organizational structures. It is suggested that the feminization process will cause an augmentation in the demand for part-time work which in turn will force hospitals to become more family-friendly institutions. According to some scholars and physicians, an increase in part-time work will negatively affect the continuity of patient care ("Women Docs 'Weakening' Medicine", 2004). With more doctors working part-time, it will become difficult to provide 24 hour quality care. Others like Jane Dacre (2008) herald the increase of women doctors arguing that it will lead to more family-friendly work policies and more women advancing to leadership positions. But do women indeed influence medicine's organizational structures and how exactly does this present itself?

In the paragraph on organizational structures in the surgery department I have elaborated on the difficulties surrounding part-time work opportunities due to the organization of specialist training and a strong organizational culture where long

work hours are perceived an inevitable part of being a surgeon. Interestingly, when I asked my interview participants about the effects of the feminization process on medicine, they answered that it will increase the possibilities for women to combine a family with a career. Not only in specializations such as internal medicine, but also in surgery.

> „Ich glaube schon, dass es da einiges so gegeben hat, auch was so Karriere und Familie und so betrifft, das ist schon_ hat, glaube ich, schon zugenommen. Also, früher hat man dann schon irgendwann Medizin gemacht und dann hat man gesagt, ‚Ja, gut, ich mache aber nur bis zu einer Assistenzarztstelle, will kein Oberarzt werden, weil, ich kriege Kinder und dann kann ich mir das eh' nicht leisten', aber heutzutage ist das jetzt nicht unbedingt ein Problem. […] Also, ich glaube, es gibt ja auch ganz viele Frauen, die eben halt auch Familie haben, die noch nebenbei irgendwie ganz andere Sachen noch machen, und trotzdem eben halt gute Medizinerinnen sind, sowohl in der Inneren Medizin auch z. B. als auch in der Chirurgie." (Ms. Toman)

Ms. Toman explains how the feminization process has created more room for women to combine a career with family life. She states that there are more and more women who have a family and nevertheless are good doctors. As if having a family principally reduces the chances of being a good physician, or at least to be as good as those who are free of obligations in addition work. This once again shows how persistent the image of a good doctor as an unencumbered worker is. The next excerpt in which Ms. Bluhm elaborates on the influence of feminization on work structures underlines this image. She is of opinion that in the upcoming years, more opportunities will emerge for women to combine family obligations with a career. In the near future, it might even be an option for senior positions to be shared or filled with part-time appointments.

> „Und ich glaube, das ist auch kombinierbar mit Familie, insbesondere jetzt so in der nächsten Zeit und so, da wird es die Möglichkeiten einfach geben und immer mehr

> Chefs und immer mehr Kliniken werden sich auch darauf einstellen müssen und, wie gesagt, dann_ Vielleicht wird man sich dann eine Oberarztstelle teilen mit einer anderen Frau oder wie auch immer. Oder man kann vielleicht auch als Oberärztin irgendwie halt 75 % arbeiten oder so etwas, 'ne. […] Aber noch sind wir, glaube ich, nicht so weit. Und noch gibt es auch genug Männer, die die Positionen erfüllen können. **[…]** Ja, ich weiß gar nicht, ob die bevorzugt werden, aber die stehen zur Verfügung! So. Die sind halt immer da. Die sind halt 100 % da." (Ms. Bluhm)

As Ms. Bluhm explains in this excerpt, although the future may bring more part-time jobs, so far there are still enough men to do the job. It is not necessarily the case that men are preferred over women, but they are full-time available. This excerpt highlights the functioning of a gendered organization in which men are primarily the unencumbered worker with no obligations outside the work sphere and therewith more suitable for the job. According to Ms. Bluhm, grave changes in the departments work structure will not take place as long as men are available to do the job.

4.1.3.2 Feminization of Practice

The discussion surrounding the feminization of medicine not only talks about possible changes on an organizational level, an increase in female physicians will also alter the content and practice of care. This argument is based on the idea that men and women harbor distinct qualities and therewith act differently on the job. The physicians in the surgery department have a somewhat different opinion when it comes to the influence of the feminization process on the practice of medicine. Most of them argue against gender differences in the comprehension and execution of the job.

„Das Geschlecht hat in der Regel mit dem, was wir tun, nichts zu tun. Also, die_ Es geht um_ erst einmal natürlich um das Verständnis der Krankheit, das ist geschlechterunabhängig selbstverständlich." (Mr. Schneider)

Mr. Schneider states that generally, gender has nothing to do with the work in the department. Herewith, he completely neutralizes gender differences. He even argues that it is self-evident that an understanding of medical knowledge has nothing to do with being a man or a woman because it is about a rational understanding of things. In his idea, rationality is something objective, not affected by personal and bodily experiences and therewith gender neutral.

„Also, eigentlich denke ich_ gehe ich davon aus, dass jeder seinen Job […] ausführt und dass man sich eben auch 100%ig verlassen kann, das ist ja auch wichtig. Ja, insofern sollte jeder ähnlich oder gleich auftreten und sich verhalten, was diese Kriterien angeht." (Mr Schneider)

In the excerpt above, Mr. Schneider continues his argument by explaining that there are certain predetermined criteria that a surgeon has to meet. According to him, gender does not play a role in this. He continues by stating that he assumes that everybody in his team performs his or her job correctly and that he can rely on that. In his comment, it seems that gender differences could endanger this trust. As if it jeopardizes the (objective) criteria for a good surgeon.

Just like Mr. Schneider, Ms. Bluhm also addresses certain qualities a physician needs to have, regardless of being a man or a woman.

„Ich_ Also, ich erwarte eigentlich, dass das jeder, egal, ob Mann oder Frau, hat. Also, das muss man eigentlich erwarten. Wenn man Arzt ist, dann sollte man einfühlsam sein, egal, ob man ein Mann ist oder eine Frau, und man sollte auch analytisch denken

können, es zumindestens zu versuchen, egal, ob Mann oder Frau. Sollte so sein." (Ms. Bluhm)

In the next excerpt, Ms. Adler makes a reference to the influence of gender differences on the execution of medical practices. She states that it is not *allowed* for gender to influence surgical operations. She does not completely deny the fact that gender differences are existent, but they need to be 'shut off' in the operation theatre. In there, guidelines and standards determine how work is being executed, not gender. If gender differences would play a role this would compromise the neutrality and, therewith, the objective standards this work is based on.

„(überlegt) Glaube ich eigentlich nicht, weil_ Ich glaube, dass man trotz alledem ja_ Also, ob Frauen oder Männer, die Aufgaben in vielen Bereichen müssen ja dieselben bleiben einfach, also, so praktische Tätigkeiten auch wie Operieren oder so. Und das darf ja nicht beeinflusst werden davon, ob es jetzt eine Frau oder ein Mann ist. Das glaube ich nicht." (Ms. Adler)

Ms. Mohr emphasizes Ms. Adler's argument by stating that a doctor is a doctor, not a man or a woman. Just like Acker's abstract worker who has no body and no gender, being a doctor means being free of gender.

„Das ist eigentlich absolut gleich. Arzt ist Arzt, ob es Mann ist oder Frau ist, es ist so. […] Du bist Arzt oder du bist nicht Arzt. Ob man Mann oder Frau ist, das ist gleich." (Ms. Mohr)

Where most of the physicians do not see any gender distinctions, Ms. Toman has another opinion on this matter. She does see differences between men and women when it comes to the practice of medicine with women being more delicate and careful when it comes to surgical operations.

„Und ich glaube, in der Chirurgie_ Ich glaube schon, dass die Frauen feinfühliger sind und einfach auch genauer operieren, vielleicht manchmal vorsichtiger, aber die sind dafür einfach auch genauer, und das, was sie dann machen, dann machen sie es halt auch lieber ganz gut und vorsichtig, bevor man da mehrere Sachen macht, die dann vielleicht nicht so_ nicht so optimal sind. […] Ich_ Ich_ Ja, ich denke schon. Also, ich denke so, die Männer sind ja auch so ein bisschen so manchmal so_ geben sie so_ echt ‚Bin so der Held, bin der Chirurg, und ich kann!', 'ne. Und da muss da manchmal einiges so schneller gehen, und das ist, glaube ich, bei Frauen nicht_ Also, wir können auch schnell operieren, es kommt auch immer auf die Erfahrung an, aber ich glaube, Frauen sind einfach so genauer. Oder beschäftigen sich auch einfach so mit den Patienten genauer oder nehmen sich auch mehr Zeit und gucken noch einmal: Muss das denn auch gemacht werden? Also, dass man halt einfach so_ Ich glaube, da ist_ da gibt es schon Unterschiede zwischen Mann und Frau. In der Chirurgie zumindest." (Ms. Toman)

Ms. Toman explains that gender differences in practicing style mainly have to do with the fact that women take more time. Men work faster and are therewith not as accurate as women who for example look at a patient twice to see what needs to be done exactly. Mr. Peper also refers to female physicians being more exerted and scrupulous.

„Also, wenn man jetzt so klar fragt, wo man vielleicht Unterschiede sieht zwischen weiblichen und männlichen Assistenten, dann könnte man sagen, dass ich vielleicht den Eindruck habe, dass die weiblichen Kolleginnen etwas gewissenhafter oder sehr bemüht sind eben häufig, und eben sie das sehr gewissenhaft erledigen werden, Männer vielleicht eher orientiert sind, dass irgendetwas schnell erledigt ist und vielleicht das nicht so bis ins Detail bedenken." (Mr. Peper)

The accuracy of the female physicians in the surgery department appears in the way they take care of the ward. Although the physicians in the Surgery department do not see any differences between men and women when it comes to medical activities, an exception is made with regard to ward work. In this case, the general opinion is that women take better care of the ward and have a more considerate approach toward patients.

> „[…] Es gibt_ Es wird unterstellt, sagen wir einmal so, dass vielleicht die weiblichen Mitarbeiter mehr fürsorglich sind oder so. Vielleicht ist das auch so. Mein Eindruck ist der, dass_ dass die Frauen die besseren Kümmerer sind, wenn Sie verstehen, was ich damit meine. […] Also, das hat ja so etwas mit Fürsorge und so etwas zu tun. Dass die Herren vielleicht etwas mehr Selbstbewusstsein an den Tag legen, was nicht immer berechtigt ist, ist auch eine typische Erfahrung, die man so macht, und die weiblichen Mitarbeiter vielleicht ein kleines bisschen zurückhaltender sind in ihrer Selbstdarstellung. Was das Analytische angeht, also das, was man wirklich täglich braucht zum Verständnis des_ des Fachs, da sehe ich keine Unterschiede." (Mr. Schneider)

Mr. Schneider states that women are more caring. But he also immediately states that these gender differences are not present when it comes to the analysis of diseases. Here, a clear separation is made between ward work, where gender differences are present and allowed, and the analytical and operational part of the job where gender differences are neutralized. Mr. Peper also refers to gender differences in ward work. Traditional feminine qualities are welcomed in this part of the job.

> „[…]der Stationsalltag wird natürlich hier schon im Wesentlichen getragen von der fleißigen Arbeit natürlich der Assistenten, und da sind eben auch viele Assistentinnen dabei, die sich da gut kümmern und bemühen. Vielleicht ist das ein Ausdruck, dass hier diese Abläufe einfach gut funktionieren im Moment, dass da eben viele gewissenhafte Leute dahinter sind, die sich da kümmern und am Ball sind, das könnte

man so sehen, ja. […] Also, ich würde jetzt sagen, dieser typische Kümmer-Aspekt, so ich kümmere mich, dieses Fürsorgliche, dass man Patienten begleitet, das könnte vielleicht eher dann auf eine Feminisierung schließen lassen. Das finde ich schon auffällig, dass viele der Kolleginnen sich da wirklich dann auch reinknien und sich auch dann um Familie des Patienten kümmern, um das Umfeld, dass dann alles passt." (Mr. Peper)

As the above comments show, the physicians differentiate between surgical operations and ward work with regard to gender distinctions. Where in the former possible gender differences are neutralized, they are explicated in the latter. Women are allowed to show other behavior and bring distinct competences concerning ward work and patient care. The women in the department take on this role of caretaker. According to Ms. Toman, this is because men simply do not see the work that needs to be done. They are busy with their careers and therefore more focused on surgical operations.

As I have elaborated above, gender differences are expected and allowed in ward work but not when it comes to surgical activities. But what does this mean for the influence of feminization on the practice of medicine? Where and how does it manifest itself? According to Ms. Adler, because women have more soft skills and are more caring, feminization might engender a climate in which personal engagement becomes as relevant as professional competence.

„Ich weiß nicht, ob sie es im Moment schon macht, aber vielleicht ist es irgendwann so, dass so_ Ja, ich meine, Frauen wird ja zumindest einmal zugeschrieben, dass sie irgendwie sensibler sind und vielleicht so ein bisschen weicher insgesamt, und dass man_ Klar, es gibt auch viele einfühlsame Männer, die sich mit den Patienten unterhalten, aber vielleicht, dass irgendwie so eine persönliche Schiene wichtiger wird als nur Kompetenz. Also, ich meine, Frauen sollten genauso kompetent sein wie Männer natürlich, aber dass eben nicht nur das Fachliche, sondern auch das Persönliche vielleicht mehr in den Vordergrund kommt. Weil ich glaube, dass früher,

wenn die Leute gesagt haben so, ‚Ja, Ärzte, das sind halt so Weißhaarige mit Bart' und so diese alten Professoren und_ Ja, ich glaube, da ging es nicht so darum, ob jemand jetzt einfühlsam ist, viel Empathie hat oder so. Und ich glaube vielleicht, dass so etwas dann mehr in den Vordergrund rücken könnte, zusätzlich zur Kompetenz natürlich." (Ms. Adler)

In this excerpt, a difference is made again between surgery and patient care. When it comes to professional competences, women need to be as competent as men, but when it comes to personal skills, women are allowed to add something. Thus an increase in female physicians could lead to a climate where in addition to competence, soft skills become more valued. With regard to gender differences in medical practices, Ms. Bluhm does not see any distinctions between male and female physicians.

„Ich weiß nicht. Meinen Sie, ob das irgendwie emotionaler wird oder man anders auf die Patienten zugeht oder man_? Nein, das sehe ich gar nicht so. […] jetzt in Bezug auf Frauen oder dass es deswegen irgendwie_? Ja, es ist ja die Frage: Was ist denn weiblicher dann oder fraulicher? Ich_ Wenn man jetzt so die klassischen Attribute dann vielleicht so für so eine weiche, emotionale Frau nimmt oder fürsorglich oder irgendetwas, dann glaube ich nicht. Also, ich glaube, da ist einfach zu wenig Zeit für. Und ich weiß nicht, wie meine Kollegen, männliche Kollegen, wenn sie mit den Patienten allein sind, ob die anders mit denen reden als ich. Aber man kriegt dann auch als Frau, wenn man ein paar Jahre in diesem Job ist, ja eine gewisse, ich will nicht sagen ‚Härte', aber man kann ja auch nicht_ Man kann ja die Fälle nicht auf sich zu_ also, zu sehr nahe an sich heranlassen, ja, das geht ja gar nicht, sonst geht man ja selbst vor die Hunde. Und von daher ist man, glaube ich, genauso_ Irgendwie geht man rational und strukturiert an die Patienten, an die Arbeit, an die Gespräche heran und" (Ms. Bluhm)

In her opinion, the feminization of medicine has not engendered alterations in patient approach because doctors simply do not have the time to be more caring and because

in order to be a surgeon, you need to develop a certain toughness and emotional distance from patients. Another reason for the little effect feminization has on medicine according to Ms. Bluhm is the fact that in most medical institutions, management positions are still filled by men.

> „(überlegt) Also, das, was ich jetzt so überblicken kann, zumindest für die Chirurgie die letzten acht Jahre, glaube ich nicht. Also, ich weiß nicht. Ich_ Dadurch, dass irgendwo so der Kopf der Abteilungen in den meisten Fällen ja irgendwo männlich ist und auch die Oberarztriege in den meisten Fällen männlich ist, sind, glaube ich, die_ also, glaube ich nicht, dass sich da so viel verfraulicht hat oder feminisiert hat, also, weil_ […] Ich glaube, dass die, also, die Frauen, die jetzt in der Chirurgie bleiben und da auch höhere Positionen anstreben, auch eine gewisse Härte brauchen, eine gewisse Durchsetzungskraft, Autorität. Und ich glaube, dass das dann auch eigentlich keinen Unterschied mehr macht, ob man jetzt Frau oder Mann ist da. Also, zumindest beobachte ich das so in den_ die Fälle, die ich dann kenne, die es dann vielleicht ‚zu Mehr' gebracht haben. Aber es gibt_ Es hat jetzt nichts mit nett oder unnett zu tun oder so etwas, aber einfach sehr klar strukturiert und Macher halt, und dann ist es, glaube ich, egal, ob Mann oder Frau, also_" (Ms. Bluhm)

Women who want to make it to the top need a high dose of toughness, perseverance and authority in order to advance to high rank positions. Since women need to show qualities that are designated as typically masculine to even make it at all, the higher ranks in surgery remain dominated by masculine traits. Because feminine qualities do not match with the image of a chief physician, these are not expressed by the women who want to advance in order to make it to management positions. The upper ranks thus remain masculine which in turn has its effect on the extent of feminization in the department at large.

4.1.3.3 Stereotypes and Gender Behavior

As elaborated in the paragraph on gender identity, the latter cannot be spoken of as a fixed ontology, but rather as a social construct produced in society and through the division of labor (Butler, 2010; Acker, 1990). As such, gender identities are produced and expressed in the Surgery department as well. Gender identities are strongly tied to stereotypes that not only describe but also prescribe gendered behavior (Durbin and Fleetwood, 2010). Research in the department has pointed out that characteristics like caring, communication skills and compassion are designated as typical female and that traits such as analytical competence, assertiveness and goal-oriented behavior are thought of as being more masculine. With regard to the expression of these traits and characteristics, a distinction in gender typical behavior is made between ward work and surgical operations. Women are allowed to show gender typical behavior in ward work because it is generally expected of them to be caring and understanding and communicative. But when it comes to surgical operations, these perceived gender differences are neutralized and specific behavior is no longer accepted. Gender differences are thus only accepted when they conform to general stereotypes and as long as they do not harm the specialist side of the profession. In the department, surgical operations are the core of medical practice; it is what the department excels in. Gender can and may not influence this in any way because it would mean that the outcome of medical practices such as surgical operations does not only rely on objective standards and guidelines that guarantee quality, but that it is the person behind these guidelines with a gender, private life and personal ideas that determines the course, outcome and success of surgical operations. Gender differences are allowed and even welcomed in ward work and patient care because this cannot do harm to the professional status and quality of surgery, and because it matches general stereotypes about men and women.

4.1.5.3 Vertical Segregation

Even though surgery has experienced an increase in female physicians, women's advancement into senior and especially chief physician positions seems to fail to appear. Generally, only 8% of the chief physicians in Germany's medical institutions is female, but in surgery this number is even less. According to the last statistics provided by the German Medical Women's Association in 2008, only 1.6% of the chief physicians in surgery in Germany are female ("Mit Skalpel, Kompetenz und Empathie", 2008). Why are there so few women in top level positions? The physicians in the surgery department gave several explanations for this vertical segregation, the main reason being the incompatibility of a career with family responsibilities. But there are other explanations brought forward as well. Mr. Schneider for example, believes that it is only a matter of time before women will develop to senior and chief positions. The current generation of chief physicians is still male dominated because for 20 years there where far less women in medicine than is currently the case. With so many women entering medicine, Mr. Schneider says it will only take five to eight years before these women gain their specialist degree and from there advance to senior and chief level positions. The question remains, though, if in ten years gender segregation on a vertical plane will be more outbalanced. According to many physicians in the department, the fact that women do not take on high level positions has not so much to do with numbers, but rather with the incompatibility of such a position with family life. The timing of family grounding coincides with the years of career making. This problem of reconciling a family with a career affects women more than men because they are not allowed to perform surgery during pregnancy. Furthermore, women are in most cases still the ones primarily responsible for the upbringing of children, making it difficult for them to be full-time available at work. According to Ms. Toman, reconciling a family life with a career in surgery is harder to accomplish in surgery than in other specialties such as internal medicine due to the attendance requirements. And although Mr. Schneider is of opinion that in a few

years more women will have advanced to senior and chief positions, he also acknowledges the difficulty for especially women to reconcile work and private life.

> „Wie ich vorhin schon einmal angedeutet habe: Wenn jemand Karriere macht, Familie und Kinder in der Zeit zwischen 25 und 35 bekommt, dann stoppt das, unterbricht das die Karrieremöglichkeiten, glaube ich. [...] Das habe ich erlebt, dass das eben dann unterbrochen wurde mit dem Facharzt, das war dann aber auch der richtige Zeitpunkt zu sagen: Ich möchte jetzt einmal Kinder haben. Also, man ist dann ungefähr so 33, 32, 33, 34, dann läuft die Uhr langsam, und dann ist es sicherlich auch eine nachvollziehbare Entscheidung, dass dann die Karriere hintenan steht erst einmal, [...]" (Mr. Schneider)

As soon as women decide to ground a family, it stops their career options. This vision repeatedly comes back in the interviews. Women have to either decide to have a family, or to pursue a career. Reconciling these two is simply seen as a mission impossible forcing women to make a choice between either one of them. As Ms. Ott explains, it is not that women are denied access to high rank positions, but rather that women do not want them because they decide to have a family.

> „Nein, ich glaube nicht, dass der Zugang verwehrt wird. Ich glaube schon, dass es viele nicht wollen, weil_ Wenn man Karriere machen möchte, dann muss man das genau in dieser Zeit machen, wo man auch Kinder kriegt. Und ich glaube nicht, dass man das gut kombinieren kann, oder mit Abstrichen, aber dann auf beiden Seiten. Also, sowohl_ Wenn man jetzt ein Kind kriegen würde, dann habe ich weniger Zeit für die Arbeit oder weniger Zeit für das Kind. Wenn ich sofort wieder arbeiten gehe, um mich da wieder richtig einzubringen, dann leidet das Kind. Und andersherum leidet die Arbeit. Ich glaube, das ist schwierig. Und meiner Meinung nach ist, ob man da ein Betreuungsangebot oder_ Das kann man alles machen, aber ich glaube, man selbst hat ein Problem damit. Wenn ich jetzt ein Kind bekommen würde, dann würde ich mich

auch um das Kind erst einmal kümmern wollen, weil, das ist, glaube ich, ganz wichtig. Und dann möchte ich nicht, dass das jemand anderes macht, die erste Zeit. Also, ich glaube, das ist das Problem. Und mit Fünfzig kann man keine Karriere mehr anfangen, dann kann man nicht anfangen und kann Richtung Chefarzt gehen, das ist zu spät, denke ich. Ich glaube, das ist genau die Zeit, wo das_ wo man sich entscheiden muss: Möchte ich jetzt eher das oder eher das?" (Ms. Ott)

According to Ms. Ott, the problem of reconciling a career with family life lies with women themselves. They have an issue putting children in daycare. Therewith, offering daycare is not going to solve the problem. As this excerpt shows, what it takes to be a good mother is irreconcilable with the time investment expected from a chief physician. The physicians in the department have an image of a chief physician as somebody who is always present. So they underline the image of a chief as someone who is unencumbered and full-time available. Therewith, they themselves would not match their own understanding of the job if they would combine such a position with a family.

„Als Chefärztin sehe ich das problematisch, weil ich_ Ich erwarte von meinem Chef, dass der präsent ist, dass der weiß, was läuft in der Klinik, und dass er ein Vorbild ist. Und zwar ist natürlich ein weiblicher Chefarzt, der Familie hat, auch irgendwo ein Vorbild, aber man kann nicht für Familie und Kinder da sein und 100 % den Klinikalltag mitüberblicken, das kann man nicht. Und jeder, der das behauptet, dass er das kombinieren kann, das glaube ich nicht. Also, glaube ich nicht." (Ms. Bluhm)

Career-making is thus inherently linked to long work hours which automatically makes it harder for women than for men to pursue a career. But even if women decide against having children and fully focus on their career, they need a lot of self-confidence and perseverance in order to be accepted as chief physician. This shows that the reason why so few women are in high level job positions not only has to do

with family grounding but also with a gendered image of a chief physician that is expected to show typical masculine behavior. This makes it more difficult for women to become accepted as chief.

> „Also, wenn man jetzt wirklich_ Wenn man jetzt sagt, ‚Gut, ich möchte gar keine Familie und ich bin darauf fixiert, nur das zu machen', dann, klar, ist, glaube ich, auch_ dann stehen einem schon die_ die Türen offen. Wobei, wie gesagt, trotzdem in der Oberschicht, sagen wir einmal in den oberen Positionen, sind einfach Männer häufiger auch in der Chirurgie. Und da muss man sich schon, glaube ich, da brauchst du auch ein Selbstbewusstsein, glaube ich, bis du dann dich durchkämpfst und auch als Chefärztin dann akzeptiert wirst." (Ms. Toman)

The male and female surgeons in the department themselves do not want to take on a chief position either. When I asked them about their career plans, they all stated that they do not have the ambition to become chief because they see it incompatible with private matters and family life and they rather have a family than a career.

> „[…] ich könnte mir z. B. auch nicht vorstellen, wenn ich jetzt irgendwie zwei Kinder hätte, dass ich_ dass ich diese Arbeit so machen könnte. So wirklich von mor_ und dann eben halt: Als Oberarzt hat man da ja noch eine andere Verantwortung und man ist dann noch länger in der Klinik und man ist auch an vielen Wochenenden hier. Und ich glaube, das ist eben das." (Ms. Toman)

Just like Ms. Toman., Ms. Mohr is not willing to take up the job of chief physician either. She is not prepared to make the sacrifices that come with such a position.

> „‚Ich habe keine Lust.' Zum Beispiel persönlich, ich würde ungern eine Chefarztposition annehmen. Ich finde_ Ich liebe meinen Beruf, aber ich liebe auch mein Privatleben, und wenn ich sehe, mit wie viel Zeit da ich aufwenden muss für diesen Job, das ist ein Fulltimejob, das ist auch nicht der Job, dass man einfach nach Hause

geht und alles vergisst, sondern man macht sich auch Gedanken über Patienten." (Ms. Mohr)

So where the literature suggests that the feminization of medicine leads to more women in high rank positions, the female physicians I interviewed are not interested in taking on this job. Neither do they understand it necessary to redefine the concept of career or motherhood in order to make these two better compatible.

4.1.4 Organizational Change

Over the last years, the department of Surgery has experienced a numerical feminization. How has this influenced the profession in general and the department in particular? The idea behind a feminization process is that women have different traits, characteristics and ideas about work than men. When the number of women working in a profession that has previously been male dominated increases, it will change the profession. But as many sociological theories have pointed out, organizational change does not just come about when new members with different ideas enter a profession. How an organization changes depends on the relative strength of structure and agency. The structural side in this case refers to the Surgery department, but also the hospital, medicine as an institution, the medical discourse and culture and society at large. Agents are the physicians who work in the department and with their actions influence the structural environment. The interplay between structures and agents determines organizational change. Through their actions, agents elaborate a systems' given form, resulting either in transformation or reproduction.

In the case of the Surgery department, a big discrepancy exists between the expectations of feminization and the actual transformation of those ideas into practice. According to the physicians in the department, feminization has made it

possible for women to make a career in surgery. In the near future, it will lead to more women in high rank positions, increased work-life balance possibilities and part-time work. However, when it comes to the conversion of these thoughts and wishes into structural transformation, change remains out. The reasons behind this failure are diverse. On the one hand, the physicians experience what Archer calls structural constraint. The department is built up in such a manner that part-time work is difficult to arrange and most of the doctors simply do not see a possibility for change. Like Ms. Ott says: „Ich glaube, man muss sich entscheiden, weil die_ Ich weiß nicht, wie man die Strukturen ändern würde." The physicians seem stuck in their conviction that structures are unchangeable reasoning that they have always been like this and will therefore not change.

> „Nein. Also, ich (lacht)_ Weil, das wird sich nicht ändern. Wir haben hier diese_ Also, diese Arbeitszeiten sind schon_ Eben, als ich Student war und hier war, war das schon genauso und_ Die Arbeit ist eben zu tun, […]" (Ms. Adler)

Another factor lies in the lack of support from higher ranks for structural change. Most of the physicians in the department do not have the feeling they are in the position to change anything. They state that change has to come from higher hand.

> „Ja, was müsste passieren? Ja, gut. Entweder man müsste sagen, gut, man macht halt die Überstunden und es muss dann von oberer Stelle kommen: Die werden bezahlt, die Überstunden. […] aber das ist hier schwierig zu machen, weil man einfach von oben keine Unterstützung hat, das ist einfach so. Und wenn gar keine Unterstützung ist, dann braucht man auch nirgendwo hinzugehen." (Ms. Toman)

Significant about the pronouncements of Ms. Ott, Ms. Toman and Ms. Adler is that they are much depersonalized. They talk about what the feminization of medicine will change about the medical institutions, but they do not situate themselves as

actors in that feminization process. As such, their statements remain part of a larger discourse on the feminization of medicine, but do not become incorporated. They do not position themselves as actors that can engender change in the organization. According to them, things will not change because they have always been this way.

As a result of the non-incorporation of the feminization process, the men and women of the department want structures to alter and expect feminization to bring this change. But they hesitate to take action and engender transformation. The main reason for their reluctance is that they do not feel that they are in the position to change anything. The department has strong hierarchies and decisions on change have to come from higher hand. Ms. Toman already expressed the necessity and simultaneously the lack of support from higher ranks for structural change. Ms. Bluhm also states that she is not in the position to change things.

> „Aber im Moment habe ich jetzt hier sicherlich noch nicht so die Position, wo ich mit irgendwelchen Verbesserungsvorschlägen (lacht) komme." (Ms. Bluhm)

For the women in the surgery department, their position in the organization makes it difficult for them to influence organizational processes, they need to advance to higher positions in order to be able to engender change. But as elaborated on in paragraph 4.1.5.3, women hardly develop to such levels because they do not feel like taking on the job and because they face structural constraint. An extensive medical training and the incompatibility for especially women to combine a career with family are barriers on women's road to the top. Archer (1990) argues that degrees of freedom are not the same for all persons and in all structural circumstances. It depends on the position of the agent and his or her structural environment if transformation comes about. The physicians in the department literally feel that they are not in the position to engender change even if they would want their actions to result in structural reproduction instead of transformation. As a result, rather than

bringing change, the increase of female physicians in the surgery department has led to structural reproduction.

4.2 Department of Internal and Integrative Medicine

The department of Internal and Integrative Medicine was started in 1999. It consists of several different autonomic units such as a center for traditional Chinese medicine, a center for traditional Indian medicine and a ward where different types of alternative and integrative medical approaches are applied such as herb therapy, acupuncture and neural therapy. The type of medicine practiced in the department is referred to as CAM. The ward of the department consists of 54 beds where patients stay for a period of two weeks. Most of the patients who come to the clinic have lasting pain or other chronic illnesses. The composition of the department's patients consists mainly of women. The same goes for its physicians with 14 of the 21 physicians being female.

For this study I interviewed two senior physicians and five assistant physicians who work in the hospital ward. Their main responsibility lies in the caretaking of patients who stay on the ward. Because of the particular type of medicine that is being practiced in the Internal and Integrative Medicine department, their medical responsibilities are reduced to regular ward work only, relieving them of emergency cases. The doctors do have night and weekend shifts, but because these are shared with other departments in the hospital they are only ones or twice a month.

The department of Internal and Integrative Medicine has always known a high number of female physicians. Nevertheless, it has experienced an even stronger increase in women doctors over the last years. Currently, seven of the eight assistant physicians are female. Additionally, there are three male senior physicians and one

head of department who is also a man. Because of the high number of women, and their feminine way of doing medicine, the organizational culture in the Internal and Integrative Medicine department differs from the department of Surgery.

4.2.1 Organizational Culture

Traditionally, CAM has always been a feminine specialization. Not only the users of alternative medicine are predominantly women, also most of the practitioners are female (Cant and Watts, 2012). Furthermore, a research conducted among medical students showed that female students are significantly more positive toward CAM than male students (Greenfield, 2006; Sarah Vader, 2012). The type of medicine that is practiced is perceived as being soft and feminine as well. Women are drawn to alternative medicine because of its preventive, caring and person-centered focus. Scott (1998) even goes as far as claiming that CAM approaches to be a feminist medicine because it challenges the ontological dualisms of biomedicine by rebalancing the power relation between practitioner and patient, specifically by giving credence to clients' experience of their own health and bodies and by sharing the responsibility of healing (Scott, 1998).

The physicians in the department also often refer to CAM as a feminine specialization where traditional female qualities are more valued and acted out than in other medical specializations. These characteristics are important in the interaction between personnel and in the practice of medicine. The department does not have a strict hierarchical system but more of a democratic and emotional way of dealing with each other. As Mr. Guhl, a senior physician in the department explains, in other hospitals, occupational groups usually work against each other instead of cooperating with each other. In the department of Internal and Integrative Medicine, people with different job positions work together as a team, creating a positive atmosphere. According to Mr. Guhl, the good working environment has partly to do with the

management structures in the department. Instead of maintaining a strong hierarchical structure where the upper ranks make the decisions and delegate to the rest of the team, the head of the department tries to create a harmonic and democratic atmosphere where physicians enjoy working.

Besides a distinction in work environment, the department's prevalent ideas on healing and caring also differ very much from conventional medical practices. CAM's special status within the larger medical domain is frequently emphasized in the interviews. Statements made about medicine in general are often followed by examples about 'how we do things differently here'. These differentiations lie in the particular way of doing medicine as well as in the organizational culture of the department.

The department's organizational culture is marked by cooperation, emotional competence and good communication. Soft skills are more important than cognitive medical knowledge or sleight of hand. Because of the particular way of doing medicine, certain qualities like emotional handling, good communication and inner peace are seen as important characteristics for doctors. Mr. Guhl explains how the personnel in the department live out and value these traits that he refers to as female.

> "[...] ich glaube, dass wir, […] speziell einfach in dieser Abteilung, vielleicht sehr viel weibliche Anteile schon ausleben, also, das heißt, uns auch solche Soft Skills einfach auch wichtig sind. Wie ist der mitmenschliche Umgang, wie sieht es mit der Emotionalität aus, sind die Leute einfach innerlich zufrieden, ja? Wie ist unser Umgang miteinander, auch hierarchieübergreifend, und eben nicht nur auf diese männlichen Domänen, ‚Was weiß der, was kann der auf dem Papier und wie gut ist der mit seiner Fingerfertigkeit?'" (Mr. Guhl)

The department's typical culture is reflected in the way new employees are chosen. When a new physician is appointed, it is more important that he or she fits the team than his or her experience on paper. When new personnel are chosen, all the team

members hold a share in the determination of a suitable new doctor. Interestingly, as Mr. Guhl explains, the decision for recruitment does not rest on good medical knowledge, but more on gut feeling and instinct.

> "Und so wählen wir auch unsere Bewerber aus, die müssen ja ein intensives Assessment durchlaufen. Die Chefs sagen nämlich, die müssen von allen anderen Assistenten, vor allem aber auch von den anderen Leuten im Team gesehen werden, damit die die Entscheidung treffen, möchte ich mit dem zusammenarbeiten. Und da geht es nicht darum, was weiß der, wie viele Lehrbücher hat der auswendig gelernt, sondern: Habe ich ein gutes Bauchgefühl in Bezug auf diese Person? Wir haben dann durchaus einmal Berufsanfänger eingestellt, wo wir sagten, ‚Die wissen noch gar nichts, die haben gerade Medizin studiert und sonst eigentlich keine Ahnung', aber wo wir gesagt haben, ‚Die passen richtig gut ins Team.' Und das war gut gewesen." (Mr. Guhl)

As the excerpts make visible, the department functions very different than for example the department of Surgery. It has other ways of working, of doing medicine and of interaction between personnel. This is partly the result of the type of doctors that come to work in the department. Many physicians ended up in CAM because they were unsatisfied with the way things worked in conventional medicine. In the department of Internal and Integrative Medicine, they have found a place where they feel at place and where they can practice the kind of medicine they believe is right.
Ms. Gras, for example, did not agree with the type of medicine that was practiced in conventional internal medicine. She felt that she was handling codes and diagnoses instead of treating patients. In the end she realized that she would be better at place in alternative medicine.

> „Die Naturheilkunde? Weil ich in der normalen internistischen Medizin nicht_ mich nicht glücklich gefühlt habe, weil ich_ dass_ Die Art der Medizin, die gemacht wurde, die hat mir nicht mehr zugesagt. Ich habe das Gefühl gehabt, dass ich nicht Patienten behandele, sondern Diagnosen und irgendwelche Codes bediene, und habe mich dann

> umgeguckt, was ich_ was dem eher entgegen kommt, was ich machen möchte, und habe festgestellt, dass ich in der Naturheilkunde wahrscheinlich besser aufgehoben bin, oder zumindest da dann mich so weiterqualifizieren kann, dass ich meine Patienten so behandeln kann wie ich möchte." (Ms. Gras)

Ms. Gras thus did not just end up in CAM because she simply needed a place to work, but made a well deliberated choice to work in an environment that distances itself from conventional medical practices. Ms. Gras is not the only physician who did not feel at home in conventional medicine. Mr. Hein did not have a good impression of medicine either. It was already during his studies that he became aware of the (mal)functioning of the medical system. This dissatisfied him to such an extent that after finishing his studies, he assigned himself the task to find a position where he would feel comfortable. Mr. Hein was conscious about the fact that in general, the structures in medicine demand for physicians to work numerous hours and endure a high workload. "Ganz Platt ist es so", he says, "dass ich wusste, man muss ganz viel arbeiten, ganz viele Stunden […]." Additionally, certain skills were reputable in the conventional medical world that he could not respond to, such as a high load bearing capacity and extensive cognitive knowledge. Because of how he experienced medicine during his studies, Mr. Hein was afraid he would not find his place in medicine at all. His wish was to acquire a job where he would feel at ease and where he could really *be*. Eventually he found his place in the Internal and Integrative Medicine department. Mr. Hein emphasizes how in the department things are carried out differently. Whereas in conventional medicine, physicians detach themselves in many ways from the curing process, alternative medical approaches engage with what according to him is meant with healing. So it is not only because of the different cultural norms and values that physicians are drawn to the Internal and Integrative Medicine department, but also because of the distinct practice of medicine.

According to Acker's analysis on the functioning of organizations, organizational culture not only reflects and produces beliefs about gender difference but also dictates and legitimizes gendered behavior (Acker, 1990). The organizational culture in the department is clearly associated with femininity. Not only literature on complementary and alternative medicine refers to the feminine nature of the profession, the physicians themselves also describe this matter in the interviews. In the department, gender differences are produced through the designation of particular characteristics like emotional competence and communicative skills as feminine. These traits are again linked to the qualities and actions of the department's physicians, therewith producing a certain image of how a good doctor should behave. In that way, the organization also dictates a certain culture. This appears in the recruitment process for new personnel where employees are selected on the base of qualities as mentioned above and their fittingness in the team and the department's culture.

4.2.2 Organizational Structures

The physicians' workdays in the department of Internal and Integrative Medicine usually start at 7.30 AM and finish around 4.30 PM. The department does not have to provide 24 hour care nor does it need to handle emergency cases but they do have a ward with patients that need to be taken care of. The work hours of the assistant and senior physicians are mostly filled with rounds at the ward, the writing of reports and staff meetings. Additionally, the doctors have one or two shifts a month. Generally, the physicians are able to finish their work in the appointed hours. It is only occasionally that doctors need to work overtime, and if so, this stays within boundaries and is usually followed by times with less work to do.

„Also, es gibt schon Tage, wo ich einfach ewig hier bin und auch noch immer kein Ende finde, und das macht mich schon dann unzufrieden, aber das gleicht sich irgendwann wieder aus, und von daher ist es gut." (Ms. Siebel)

The departmental structures also leave room for the personnel's own necessities. In some cases, people can depart early, leaving the rest of the work to be done the next day.

„Also, manchmal einfach, indem ich sage, ‚Okay, ich habe einen wichtigen Termin', und dann mache ich pünktlich Feierabend. Dann lasse ich auch schon einmal Sachen liegen oder schiebe halt Behandlungen auf, weil mir das schon wichtig ist, dass ich für mich selbst noch sorge. Also, das fängt damit an, dass ich donnerstags sage, ‚Okay, 16:30 Uhr ist Yoga.' Dann lege ich mir da keine Behandlung mehr hin, dann bleibe ich halt nicht länger. Genau." (Ms. Hartmann)

With regard to the excerpts above, it seems that the department's structures and cultures allow the physicians to find a balance between work and personal needs.
Still, not all physicians are satisfied with the way their work life and private life is balanced.

4.1.2.1 Work-Life Balance

The way in which organizations are structured strongly relates to the division of labor and therewith work-life balance. The experiences with work-life balance possibilities in the department are diversified. For some physicians, working 42 hours is too much and change is wished for the future. For other doctors, the current work hours are great and the balance between work and private life suits their needs.

Mr. Fischer, for example, is very content with his work-life balance. He is a senior physician and has been in the department for several years already. He is able to

manage his work hours well and has enough leisure time to organize his private life. He is married and has two daughters of five and two years old. His wife is a horse riding instructor and works the evenings. During the day, she takes care of the children and household. In the evening, when she goes to work, Mr. Fischer takes care of his daughters. He explains that although work is his primary time expenditure, it leaves sufficient hours to spend with his children.

For other physicians, the workload and time expenditure are too much. Mr. Hein explains that although many facets of his work meet his ideas and standards, the expected work hours and output disturb him.

> „ […] so wie ich jetzt arbeite in der Naturheilkunde ist es schon so, was ich gesagt habe, dass da Vieles für mich stimmt, aber dass es mir trotzdem klar ist, dass es trotzdem noch ein Teil des Systems ist, so. Und dass es da von sich auch nicht lösen kann, so, also, zumindest ist das die Situation jetzt, d. h._ […] Es gibt Strukturen, die mich stören und die das auch zeigen. […] Also, zum einen finde ich trotzdem noch, dass es eine hohe Arbeitsbelastung ist bzw. eine hohe Arbeits_ ein Arbeitsaufwand ist, den man_ der von einem irgendwo indirekt verlangt wird.“ (Mr. Hein)

Mr. Hein explains that although the department differs in how work is structured, it is still part of the larger medical system, resulting in long work hours for the physicians. For Mr. Hein, it is alright to have such a high work load for a certain amount of time, but not for the long run.

Ms. Hartmann has difficulties with the appointed work time as well. She states that intellectually she should be content with her work hours, especially when she compares her situation with that of her friends from other departments who have to work many extra hours and have more shifts than she has. In fairness, though, her work sometimes pushes her to her limits.

„Also, vom Verstand her müsste ich sehr zufrieden sein, weil ich auch sehe, was so in meinem Umfeld passiert, wie_ also, wie viele von den Freunden Überstunden machen und wie viel Dienste die machen müssen, da kann man ganz zufrieden sein. Aber ehrlicherweise bin ich auch so manchmal schon am Limit. Das ist ein wahnsinnig langer Tag. Und finde die Arbeit insgesamt sehr raumgreifend im Leben, also, das sind acht, neun Stunden, und dann bleiben einem vom Rest des Tages irgendwie noch so vier, fünf, um das restliche Leben zu organisieren. Das ist mir manchmal an manchen Tagen und an manchen Zeiten auch zu viel auch. Ja." (Ms. Hartmann)

Ms. Hartmann explains her work takes up more space in her life than she wants. For Mr. Guhl, finding a good balance between work and leisure time is also still a difficulty. In addition to the 42 hours he spends in the ward, he works on research, articles and presentations. Two weekends a month are filled with work as well so that in the end, he works an average of 50-60 hours a week. Mr. Guhl has no children that are in need of his direct care, but is not satisfied with his work-life balance. His job has gained too much importance resulting in too many weekends packed with work. His goal for the coming year is too have more weekends off of work in order to spend more time with his loved ones.

"Ähm, nicht so optimal, wie ich es mir wünsche. Also, ja, das Berufliche hat manchmal zu viel Gewicht. Also, es sind oft zu viele Wochenenden ausgefüllt. […] Also, ich werde auf jeden Fall im nächsten Jahr dann ja auf mich achten, d. h. ich habe meine Terminplanung, was z. B. Kursaktivitäten betrifft, das geht ja mindestens immer ein Jahr schon voraus. Das heißt, ich habe für das nächste Jahr schon einige feste Termine stehen, und habe jetzt angefangen, einfach freie Wochenenden, die ich habe, zu blockieren. Dass ich sage, also_ Mindestens zwei Wochenenden im Monat streiche ich mir raus, die sind für mich. Da kommt dann kein beruflicher Termin. Also, wenn dann Vortragsanfragen kommen, werde ich die absagen." (Mr. Guhl)

As Mr. Guhl explains, it is the extra workload that is too much for him. The normal work hours are fine considering the fact that it used to be a lot more. Just like Ms. Hartmann, Mr. Guhl states that he should be content with the work hours in the department in comparison to the workload in other hospitals.

> " […] Ähm, jetzt wäre es für mich einfach schon ein Fortschritt, wenn ich mehr Wochenenden für mich frei halte, und ich glaube, damit wäre ich dann auch zufrieden. Also, ich fühle mich sonst, wenn hier acht Stunden gearbeitet habe, fühle ich mich jetzt nicht überlastet, sondern das ist völlig in Ordnung. [..] Ja, ich meine, früher haben wir noch länger gearbeitet, da waren das 70 bis 80 Stunden, von daher ist das ganz_ ist das toll, wenn man nur 42 Stunden arbeitet, dann ist das grandios, dann hat man richtig eigentlich Zeit." (Mr. Guhl)

Mr. Guhl does not feel constrained by structures when it comes to creating more room for his personal needs. He feels he has the scope and the possibility to arrange a suitable work-life balance.

> "Also, ich kann mir meine Arbeit ja relativ frei einteilen. Ich habe natürlich ein paar Fixtermine, die so sein müssen, da gibt es auch kein Dranrumdiskutieren." (Mr. Guhl)

Furthermore, he has the impression that the organization approves and supports those who wish to have some time out.

> "[…] und ich habe schon den Eindruck, dass ein Verständnis dafür da ist, das man sagt, ‚Nee, ich brauche einfach einmal auch die Auszeit für mich'. Ja, und ich denke, davon lebt auch unsere Klinik, dass es nicht darum geht, Dinge abzuarbeiten, sondern eben auch um einmal den Blick nach unten zu wenden." (Mr. Guhl)

For Mr. Guhl, there is enough room to change the current structures and adapt them to his needs and wishes. But the reason behind his possibility for change is because his wishes comply with a certain standard; the standard of the 7.30 AM to 4.30 PM workday. He wants to reduce his the extra hours he spends at work but does not question the normal workdays. As I will elaborate in the next paragraph, altering the structures of the normal workday is hard and part-time work is difficult to realize in the department's current structures.

4.1.2.2 Part-time Work

At the start of her job in the department, Ms. Ludwig asked for the possibilities of part-time work. The chief of the department answered this question with the statement that the ward cannot be taken care of with a part-time job position. "Ich habe das schon angesprochen, aber gut, das war vielleicht am Anfang, aber da hat der Chef gemeint „Nein, man kann die Station nicht mit einer Dreiviertelstelle versorgen." Ms. Gras has also experienced difficulties surrounding part-time work. She is a specialist and has worked in the department for several years now. She is married and has a six year old daughter. She started her work at the department with an 80%-job. After having experienced discrimination on several levels due to her part-time job, she decided to stock up and works full-time again.

> „[…] Ich bin verheiratet seit Jahren, habe eine sechsjährige Tochter. Mein Mann geht auch vollzeitarbeiten. Nach der Geburt unserer Tochter war ich ein Jahr zu Hause, habe da Elternzeit gemacht, danach bin ich mit einer 75-%-Stelle wiedereingestiegen, dann 80 %. Ich habe auch hier mit 80 % angefangen, habe dann nach zwei Monaten gemerkt, dass das nicht gut machbar ist, habe dann auf 100 % aufgestockt. Ja, und jetzt (schnauft), ja […] Weil in dem Stationsbetrieb, so strukturiert, wie er hier war oder ist, immer noch, ließ sich das nicht gut vereinbaren. Also, man hat_ An irgendeiner Stelle

hat man immer etwas verpasst oder_ Im Grunde war es das gleiche Arbeitspensum wie die Kollegen, nur, ich hätte es_ Theoretisch hätte ich eher gehen können, aber praktisch_“ (Ms. Gras)

Ms. Gras has increased her work hours to 100% again because working only 80% appeared incompatible with the department’s structure. She always missed out on something, and in the end often worked as many hours as her colleagues. Theoretically speaking, she could have left work early, but in practice this was hard to accomplish. She explains that as soon as you reduce your hours, you become a part-time mum. When working 80%, she was deprived of information because her colleagues did no longer perceive her as a full member of the team. But there is also a personal side to the matter. Now that she is working full-time again, Ms. Gras has the feeling of being someone. This statement visualizes how she has incorporated the image of a good doctor and feels useful now that she lives up to this standard.

„Also, ich habe das Gefühl, dadurch, dass ich wieder 100 % arbeite, bin ich auch wer. Also, ich hatte vorher das_ Sobald man reduziert, ist man ‚Teilzeitmutti’, und wenn es 80 % sind, also so minimal weniger als die anderen, dann ist man_ Man ist so direkt irgendwie, ‚Ja, ja, die kann ja nicht alles machen’ oder so ähnlich. Es ist schon ein bisschen diskriminierend. Und man kriegt tatsächlich weniger mit. Also, wie wenn man zwei Wochen im Urlaub ist, dann fehlen halt Informationen. Und das ist blöd, das wirkt sich aus.“ (Ms. Gras)

Ms. Gras continues to explain how for her personally it would be better to work part-time, but for the job and for the patients it is better to work full-time. She also has the feeling that she is treating her patients better with a full-time occupation.

„Ich habe selbst auch das Gefühl, dass ich meine Patienten besser versorge, wenn ich da bin. Das ist aber, glaube ich, persönlichkeitsabhängig. Tja. Also, ich glaube, für mich

persönlich wäre es besser, nicht so viel zu arbeiten. Aber ich glaube, für die Patienten ist es gut (lacht)“ (Ms. Gras)

The case of Ms. Gras is an interesting example of the difficulty many female physicians face when trying to reconcile their ideas on motherhood with their image of what it takes to be a good doctor. The question is if she would have felt the same way if she would have been seen as a good doctor and full member of the team with an 80% job? It could also be argued that Ms. Gras is somehow forced to inhabit a full occupation and beliefs it is better for her as well now that she is no longer the part-time mum that is not taken seriously by her colleagues, but a full member of the team again. This example subscribes that even though in the department a lot of room is prevalent for the personnel's own needs, to be a real doctor and a full member of the team, you need to be full-time available.

The reason part-time work is so difficult to manage is because of the way the department's ward work is structured. This expects physicians to be present from 7.30 AM to 4.30 PM. Another factor that plays an important part in the issues surrounding part-time work is the particular way in which care is delivered. In the next excerpt, Mr. Guhl explains how in the department a special kind of medicine is practiced that strongly relies on the personal bond between doctor and patient.

„ […] weil wir eben auch eine Medizin machen, die sehr personengebunden ist. Also, der Patient legt schon sehr viel Wert darauf, und das ist auch sehr_ davon hängt auch viel seines Therapieerfolges ab, die gleiche Bezugsperson zu haben, mit demjenigen einen Weg zu gehen, und das ist von daher schon eine Herausforderung, das irgendwie_ der wir uns dann stellen müssen, unseren Arbeitsalltag so zu planen, dass wir mit Halbtagskräften eine gute Patientenversorgung machen können. […] Wir begleiten die Patienten einfach auch auf einer sehr emotionalen Ebene, und da merken wir schon, dass es für unsere Patienten ganz schwierig ist, wenn einfach einmal ein Arzt wechselt, weil der dienstfrei ist oder so.” (Mr. Guhl)

According to Mr. Guhl, the difficulties of reconciling part-time jobs with organizational structures in the department are due to the personal type of medicine they practice. The success of therapy partly depends on the personal bond physicians have with their patients. For the patients, it is best if the physicians are full-time present. This inherently means that physicians who work full-time are somehow better caretakers. The image of a good doctor, therewith, has a lot of similarities with Acker's abstract worker who needs to be unencumbered and full-time available. Acker explains how it is often more difficult for women to meet the standards of the abstract worker since they are the ones taking care of the family. Ms. Gras is a good example of this. Because of the way in which jobs in the department are designed, it is difficult to have either less, or more flexible work hours. Inherently, this deprives women of the possibility to find a suitable solution for the combination of work and family.

An organization is made up in a certain manner with particular written and unwritten rules, norms and values. The Internal and Integrative Medicine department has a clearly structured workday from 7.30 AM till 4.30 PM. In these hours, physicians need to be present and perform their tasks. The organization's structure and culture leave room for personal needs such as yoga or time to retreat and reflect. But there is also a certain framework that cannot easily be modified. Both Ms. Ludwig and Ms. Gras have experienced this in their wish for part-time work. This also adds another dimension to the image of a good doctor. Not only female qualities such as emotional competence and communicative skills are important characteristics for a physician. The personal bond between doctor and patient is also of importance. In order to maintain this bond, physicians should be full-time present. So the type of medicine that has drawn men and women into the department also demands physicians to be full-time available.

4.2.3 The Feminization Process in the Department of Internal and Integrative Medicine

With regard to a numerical change in the gender composition, it can be said that a feminization has taken place in the department of Internal and Integrative Medicine. Mr. Guhl explains how for 20 years, most of the doctors were men. Nowadays, when he looks at the gender composition of his medical students, he asserts that there are more women than men. In CAM, he says, the number of women doctors is even higher because women are generally more drawn to CAM than men. When the department has vacancies for assistant physicians, it is mostly women who apply.

Although the department has always had a great share of female physicians, it has experienced an even further increase in women applicants over the last years. But when it comes to the effects of the feminization process on the profession, the ideas and the opinions vary. Many physicians point out that it is difficult to say if and how the feminization has engendered change. They do see that the medical profession has altered, but to them it is not identifiable if feminization has caused for this transformation to have emerged.

> „Ich finde das so schwierig auseinanderzuhalten. Die Medizin verändert sich sicher, aber der ganze Zeitgeist verändert sich auch, und die Arbeitsum_ und die Typen, die Medizin machen, sind auch andere als vorher. Insofern weiß ich nicht, ob das nur an der Feminisierung hängt, dass mehr Frauen in der Medizin sind, dass die Medizin sich verändert, oder ob das ein Phänomen unter Vielen ist. […] Das heißt, die Leute, die früher streb_ also, die Streber, die viel Geld machen wollten, waren alle in der Medizin, und die wandern aus der Medizin ab. Die wollen woanders das dicke Geld machen, und dadurch haben wir auch andere Typen. Das ist aber vielleicht auch gut. Schwierig zu sagen, wie das dann zusammenhängt.“ (Mr. Fischer)

As Mr. Fischer explains, not only medicine, but the whole zeitgeist has changed. Herewith, the doctor type has changed as well, making medicine a different kind of

profession. It is difficult to tell if these alterations are caused by feminization or if it is because the medical domain has changed that more women are entering the profession.

But where some physicians do not see a link between professional changes and feminization, others expect the feminization process to engender changes in medicine's organizational structures.

4.2.3.1 Feminization of Structure

Just as is the case in the literature discussion on the feminization of medicine, many physicians in the department connect feminization with an increase in the demand for part-time work. In the interviews, the process is referred to as a problem for women as well as medical organizations.

> „Wenn man die Zahlen so hört, dann nimmt man natürlich wahr, dass da in der Überzahl Frauen sind. Das einzige, womit ich tatsächlich jetzt, wahrscheinlich auch durch zunehmendes Alter, immer mehr in Berührung komme, ist, dass ich sehe, dass die Frauen auch_ also, dass immer mehr diese Probleme mit Halbtagsstellen auch in der Arbeit auftauchen. Und dann nicht nur Probleme, sondern auch Organisation, die das einfach bedarf, dass man guckt, wie man das macht. Also, von den Kolleginnen, die dann Kinder haben und sagen, ‚Wir müssen gucken, was wir da finden', und das merkt man auch bei uns auf der Station, dass da Strukturen gefunden werden müssen, dass das gar nicht so einfach ist zu sagen, ‚Die kommt in 50 % und die anderen in 100 %', sondern dass da wirklich sich auch alles angleichen muss. Das hätte ich jetzt mit Feminisierung verknüpft noch am ehesten." (Ms. Hartmann)

According to Ms. Hartmann, new structures need to be found to deal with the demand for part-time work. Ms. Siebel also refers to a lack of family-friendly structures in the department.

„Ja, man merkt, dass immer mehr junge Frauen in den Beruf reinkommen und dann noch ein bisschen unklar ist, wie das alles funktioniert. Die Strukturen sind noch nicht da. […] Ja, wenn viele Frauen da sind, gibt es einfach noch einmal andere Probleme. Also, wenn die Kinder kriegen, wenn die Teilzeitarbeiten wollen, da sind die Strukturen nicht überall geschaffen." (Ms. Siebel)

As the excerpts above make visible, the increase of female physicians has caused an augmentation in the demand for part-time work. In order to accommodate these wishes, new structures need to be found and established. Ms. Gras states that the departmental chiefs need to become more flexible and open-minded. She has the feeling that not all chief physicians have yet come to understand that they have to meet the requests from the new market and be more receptive toward flexible work structures.

„Ja. Ich glaube, dass es zugenommen hat, dass Teilzeitkräfte mehr sind, dass die Chefs da auch flexibler werden oder zwangsläufig, weil die Nachfrage einfach so groß ist. Und dass halt sehr, sehr viel mehr Frauen da in der Medizin angefangen haben, das stimmt schon." […] Ich glaube, das wird noch einmal richtig knallen! Im Moment habe ich nämlich den Eindruck, dass nicht alle Chefärzte das begriffen haben, dass sie dem neuen Markt entgegentreten müssen und auch mit kreativen Ideen gegenübertreten sollten und auch offen sein sollten für flexible Arbeitszeiten und solche Sachen, weil es einfach nicht anders geht. Die Frauen, die fordern so etwas. Und auch die Männer, die ich mittlerweile kennengelernt habe, die Studienabgänger sind auch so, die möchten auch nicht immer 60 Stunden pro Woche arbeiten, die möchten auch eher ein bisschen reduzieren, ein bisschen mehr auf Familie und Freizeit achten. Und wenn da nicht ein Umdenken stattfindet, dann wird es richtig knallen." (Ms. Gras)

Ms. Gras expects some trouble because some chief physicians seem not to have understood the urgency of structural change yet. The same goes for the department of

Internal and Integrative Medicine where possibilities for part-time work have not yet been realized, the main reason being the personal based type of medicine that is practiced in the department.

> „Also, was wir erleben, ist, dass einfach immer mehr Bewerberinnen auch von vornherein mit der Idee kommen, nur halbtags arbeiten zu wollen, und das stellt uns vor schon deutliche organisatorische Herausforderungen, weil wir eben auch eine Medizin machen, die sehr personengebunden ist. Also, der Patient legt schon sehr viel Wert darauf, und das ist auch sehr_ davon hängt auch viel seines Therapieerfolges ab, die gleiche Bezugsperson zu haben, mit demjenigen einen Weg zu gehen, und das ist von daher schon eine Herausforderung, das irgendwie_ der wir uns dann stellen müssen, unseren Arbeitsalltag so zu planen, dass wir mit Halbtagskräften eine gute Patientenversorgung machen können. Und das ist sicherlich anders als, denke ich, in so einem chirurgischen oder anders interventionell arbeitenden Bereich, wo man sagt, ‚Na gut, Herr Müller macht das Aufnahmegespräch, Herr Meier macht die Operation und die weitere Betreuung macht dann Stationsarzt, Stationsärztin.' Ja, und das ist bei uns doch sehr auf einer_ Wir begleiten die Patienten einfach auch auf einer sehr emotionalen Ebene, und da merken wir schon, dass es für unsere Patienten ganz schwierig ist, wenn einfach einmal ein Arzt wechselt, weil der dienstfrei ist oder so." (Mr. Guhl)

The problem is that many women come to work in the department with the idea to work part-time. Mr. Guhl explains that this causes organizational challenges due to the personal based provision of care. Just like in the department of Surgery, doctors need to be full-time available. The motivation behind this lies in the particular type of medicine that asks for a special bond between physicians and patients. As the discussion on feminization elaborates, the physicians in the department expect the increase in female physicians to result in more part-time jobs. There is also a wish from the doctors to have more flexible work possibilities but a conversion of these requests so far has remained out.

4.2.3.2 Feminization of Practice

Since CAM is already a feminized discipline, the physicians found it difficult to establish the exact effects of the feminization process on the provision of care. Furthermore, when I asked my participants about gender differences in working style, their answers varied. Some physicians did not see any differences between men and women. Others stated that women have a distinct approach to patients, but these declarations were often followed by the statement that these differences are not so visible in the Internal and Integrative Medicine department because of its feminine character. Mr. Guhl finds it difficult to say if the increase of female physicians has changed medical practices in the department because CAM is already a feminized discipline. He used to work in a surgery department with a team that consisted solely out of men. There, the interaction between the physicians was very different from the department of Internal and Integrative Medicine. He says: "Letztendlich ist das Arbeiten hier jetzt in der Einrichtung schon anders. Ich weiß aber nicht, ob das an den Frauen selbst liegt oder an unserem Arbeitsumfeld selbst." Herewith, he refers to the democratic working environment and the humane interaction between the colleagues. It is not clear, though, if this is due to the fact that there are so many women in the department, or if it is because of the typical kind of medicine that is practiced.

When it comes to gender difference in working style, some physicians state that men and women have distinct skills. These statements are often followed by an explanation that these differences are not so prevalent in the department because soft skills are appreciated qualities of both men and women.

> „Ich kann es mir vorstellen, ja. Ja.[…] Ich könnte mir vorstellen, dass es_ dass Emotionen eine größere Rolle spielen, dass da vielleicht auch mehr Mitgefühl ist und mehr persönliche Beziehung. Das ist jetzt nicht nur rein_ also, nicht nur nega_ nicht nur positiv, sondern_ Aber Frauen und Männer sind einfach unterschiedlich, und ich

könnte mir vorstellen, dass die Männer eben oft eher sachlich sind und Frauen hier so emotionale Ebene vielleicht mehr mit.“ (Ms. Hartmann)

In the excerpt above, Ms. Hartman explains that women are different from men. She uses common gender stereotypes to make these differentiations, such as women being more emotional and men more professional. She tries not to valuate any of these competences as being more positive or negative and argues that it is a given fact that men and women are dissimilar.

Ms. Siebel also sees gender distinction between men and women, and directly links this to a differentiation in patient treatment.

„Ich denke schon. Durch ein anderes Zugehen auf den Menschen, vielleicht so ein bisschen mehr Weichheit. Also, viele Ärzte, die ich getroffen habe, waren sehr direktiv und eher hart, und ich denke, ja, wenn ich so die Frauen beobachtet habe, die haben schon ein bisschen mehr Verständnis für die Patienten gezeigt.“ (Ms. Siebel)

With her statement, Ms. Siebel refers to the possible effect of the feminization of medicine. Since women show more softness in their patient approach, a feminization could lead to a different handling of patients. Even more interesting is her statement that although gender differences exist, these are not so prevalent in the department of Internal and Integrative medicine because of how soft skills are valued. This inextricably means that gender distinctions are impressionable and that organizational cultural ideas on work influence the way in which men and women perform their jobs.

„Die sind hier nicht so ausgeprägt, weil hier einfach viel Wert darauf gelegt wird, aber sie sind auch, glaube ich, unterschwellig da. Also, ich habe_ Einerseits können Männer sich, glaube ich, besser abgrenzen, so von diesem Mitgefühl von den Patienten. Ja.” (Ms. Siebel)

Where Ms. Hartman and Ms. Siebel see clear differences between male and female physicians, other doctors in the department are less convinced about distinctions in work style between men and women. Ms. Ludwig for example, does not think that differences in practice style have to do with gender identity but dedicates this to personality distinctions in general. Where Ms. Ludwig is very definite, Mr. Fischer has a more ambivalent point of view. On the one hand, he states that women have the tendency to be more empathic where men can better distance themselves. But he is very hesitant to oversimplify these differences.

„(überlegt) Kann ich nicht sagen. Es gibt vielleicht eine Tendenz dazu, dass Frauen ein bisschen empathischer sind und Männer sich eher abgrenzen. Aber das kann man auch nicht pauschalisieren. Es gibt genug Frauen, die sich super abgrenzen können. Männer, die vor Empathie zerfließen, habe ich noch nie erlebt (lacht)." (Mr. Fischer)

Mr. Fischer is very careful in his statements regarding gender stereotypes. In the next excerpt, he refers to the idea that women are less analytical than men as sexist. He does not have that experience at all. His comments are interesting especially because he is a man and clearly does not want to discriminate women. As a result, he indirectly points to gender differences followed by statements that he does not want to generalize or oversimplify. Where he does emphasize distinctions is with regard to emotional competence with women being more caring.

„Ja. (überlegt) Das jetzt gerade zu klassifizieren, das fällt mir schwer. Ich habe_ Also, was die analytischen Fähigkeiten z. B. angeht, sagt man ja_ gibt so diese sexistische Idee, Frauen könnten das nicht so gut. Das ist überhaupt nicht meine Erfahrung. Da gibt es Solche und Solche, aber die habe ich bei Männern auch genauso getroffen. Was sie nicht_ Das Mitgefühl haben Frauen tendenziell eher als Männer, aber ich habe auch den Eindruck, auch verbunden mit dem Risiko selbst, mehr von ihrem Privatleben und

von ihrer geistigen Gesundheit zugunsten des Patienten zu opfern. Was ich auch nicht für gut halte." (Mr. Fischer)

What is interesting about these excerpts is that it seems easier for him (as a man) to put the man as deviant from the woman than the other way around. Thus when he takes men as the standard, for example when it comes to analytical skills, women are not distinct, but when women are set as the norm, for example in emotional skills, men are presented as lacking these competences.

As the above excerpts show, it remains difficult for the physicians to establish straightforward effects of feminization on the practice of medicine in the department. Although some physicians see characteristic differences between men and women, these distinctions are not so prevalent in the unit. So it is not as if a feminization in medical practice is not existent at all. Rather, the effects are hard to identify since a feminine working style is already integrated in the type of medicine practiced in the department.

4.2.3.3 Stereotypes and Gender Behavior

Although the physicians in the department of Internal and Integrative Medicine are reluctant to make generalizing statements when it comes to gender typical behavior, research on stereotypes in the department has pointed out clear stereotypical differences between men and women. Characteristics like caring, communicative and compassionate are mostly designated as female and goal-oriented and assertive as male.

„Ja. (lacht) Also, bei Männern sehe ich eher so diese Zielorientierte, Ambitionierte. Und für Frauen eher so, das ist total stereotyp, das merke ich jetzt gerade, aber so dieses

> Mitfühlende. […] Ja, also, hier in der Abteilung ist es nicht so ausgeprägt, aber in der alten Abteilung war es schon so, dass die Männer eher so dieses Langfristige vor Augen hatten, so dieses ‚Was muss ich noch alles machen, um eben an meine persönlichen Ziele zu kommen', ähm, wo die Frauen dann eher haben, dass sie Patienten gut versorgen und sich da so ein bisschen reingedacht haben." (Ms. Siebel)

Ms. Siebel says that men and women simply are different. Men are more objective and business-like whereas with women, compassion and emotions play a bigger role. Furthermore, women show more softness and understanding in their approach toward patients.

Adjacent to the research on stereotypes, the physicians referred to gender stereotypes in conjunction with other themes as well. They for example often referred to CAM as a feminine medical discipline where traits like open-mindedness and good communication are important factors, therewith indirectly but automatically generating stereotypes. Interestingly, many statements about gender differences have immediately been followed by an explanation that these are not present in the department because of the feminine way of doing medicine. So gender differences are acknowledged by the physicians, but gender typical behavior is displayed when conform to the larger organizational (feminine) culture.

4.2.3.4 Vertical Segregation

As Riska (2001; 2008) has pointed out, although a numerical feminization has taken place in medicine, this phenomenon is mainly present in lower rank jobs. This disproportion is also existent in the Internal and Integrative Medicine department. The increase in female physicians has got to a point where it is difficult to even find men among the applicants. But this pattern has not emerged on a vertical plane.

Although women compose the majority of assistant- and specialist physicians, the higher ranks remain strongly male dominated. Several reasons are brought forward to explain this disparity. Some doctors relate the problem to structural and cultural barriers. They argue that in many cases, current organizational structures make it difficult for women to combine a high rank position with a family. Adjacent to it, female qualities, and therewith women themselves, do not fit the present-day image of a chief physician resulting in men more likely to get the job than women. There are also physicians who argue that it is only a matter of time before more women will take on chief positions. This argument is based on the fact that women have entered the medical profession en masse only recently and therewith have not yet reached the right age to achieve such a position. Mr. Guhl for example states that medicine used to be a male dominated profession but that with more women attending medical studies, it is likely that in the future more women will become chief physicians. A generational factor, however, is not the only aspect that causes women to remain in the lower ranks; there are also structural barriers women face on their way to the top. A career in medicine is equated with a huge time investment, making it difficult for women to combine family obligations with work.

> „Aber das wird sicherlich noch ein paar Jahre dauern, weil einfach im Augenblick das_ die Klinik noch so gestrickt ist, man ist Vollzeit da, macht Überstunden, ohne zu murren, was einfach Familie im Sinne, also, Fürsorglichkeit für Familie, sprich vor allem das Kinderkriegen komplett ausschließt in einer Führungsposition." (Mr. Guhl)

In the excerpt above, Mr. Guhl states that having a family automatically excludes the possibility of having a management position. This is not only due to spatiotemporal issues. As Mr. Hein explains in the next statement, the ideal image of a chief physician does not correspond to the stereotypic picture of a woman either. This raises the question if the incompatibility of motherhood with a chief position is only due to temporal issues or if it also has to do with an image factor.

„Und, tja, wenn du mich so fragst, glaube ich dann doch, dass das System, so wie es momentan ist, wahrscheinlich dann doch eher_ Eigenschaften, die eher bei Männern zu finden sind, wie sagt man, dass man eher mit Eigenschaften, die eher bei Männern zu finden sind, Karriere machen kann in diesem System, wie es aktuell besteht. Glaube ich schon.“ (Mr. Hein)

In the current system, masculine characteristics are believed to be more suitable in career making than female qualities, making it difficult for women to develop to high level positions. But the lack of female chief physicians cannot solely be ascribed to structural barriers. It is also the case that women do not find themselves suitable for the job. Women have not had the heart yet to take on management positions and then do the work differently. Therewith, they are reproducing the image of the masculine chief physician instead of changing it.

„Ja, es gab bislang, glaube ich, auch nicht so die Frauen, die gesagt haben, ‚Okay, ich bin genauso qualifiziert, ich traue mir das genauso zu, Leitungsaufgaben zu übernehmen, aber ich mache das anders', ja? Also, es gibt ja bestimmte Vorstellung, wie Leitung funktioniert. Und diese Vorstellung war, glaube ich, einfach von den Qualitäten, die Leitung haben sollte, sehr männlich.” (Mr. Guhl)

Ms. Gras and Ms. Ludwig elaborate on this phenomenon, arguing that women do not have enough confidence in themselves to take on a chief position. They lack typical masculine qualities like self-confidence and goal-orientation necessary to take on such a job. Mr. Guhl, though, thinks that since women are numerously entering medicine, the idea on management and the skills that come with it will change. With more women entering the profession, more women will advance to senior positions which in turn will result in more chief physicians who emphasize soft skills in their work.

„[...] Da aber jetzt eben 60% Ärztinnen da sind, wird es nicht mehr so weitergehen, dass der Großteil der Chefarztposten von Männern besetzt wird […] Ja, ich glaube, dass sich das jetzt eben verändert und dass wir in Zukunft sicherlich dann auch mehr Frauen in Leitungspositionen haben werden […] dann werden eben andere Qualifikationen, andere Sorf Skills mehr in den Vordergrund kommen." (Mr. Guhl)

But even though Mr. Guhl thinks that more women will advance to high level positions in the near future, the female physicians currently working in the department do not want to take on this task. Just like in the Surgery department, the women in the Internal and Integrative Medicine department are not aiming for a chief position, the main reason being the incompatibility of a career with family life. When I for example asked Ms. Gras if she could see herself become chief physician one day she stated:„[…]_ werde ich nicht! (beide lachen) Oberärztin könnte ich mir vorstellen, aber Chefärztin werde ich sicher nicht." The main reason women are not aiming such a job is the incompatibility of a career as chief with family life and the lack of qualities necessary in such work. As Ms. Gras explains:

„Ich glaube, dass_ Ich glaube, dass Frauen andere Ziele haben, wenn sie_ oder nicht zwingend, man kann es nicht pauschal sagen, aber_ Ich kann das z. B. an mir festmachen: Ich bin auch kein Karrieremensch, ich kann mir nicht vorstellen, Chefärztin zu werden, weil mir das nicht liegt. Ich glaube, man muss da so ein bisschen ein Alphatierchen sein, um das zu machen, und muss ein bisschen Darstellungswillen haben, entsprechendes Auftreten und_ (schnauft) […] Ich glaube, das liegt an den Eigenschaften, die sich die Frauen_das nicht zutrauen, nicht so zielorientiert sind, genau diese Eigenschaften nicht so immer haben. Ja. Auch_Ja, nicht so selbstbewusst sind. […] Da gibt es bestimmt auch Frauen, die das haben, aber ich glaube, das ist eher ein männlicher Charakterzug. Außerdem ist es viel, viel schwieriger als Frau, Beruf, Karriere, Kind und alles unter einen Hut zu bringen. Also, da überlegt man sich drei Mal, ob man einen Oberarztposten und einen Chefarztposten annimmt." (Ms. Gras)

In this excerpt, it is again argued that women lack the right qualities necessary for a management position. Interestingly, the women in the department underline the masculine image of a chief physician and apparently do not see it as their task to change this prevailing picture.

4.2.4 Organizational Change

The feminization of medicine has caused for a numerical change in the gender composition among the physicians in the department. This phenomenon has engendered changes in the organization and practice of medicine.

In general, there seems to be many opportunities in the department to influence matters. As Mr. Hein and Mr. Fischer state, within a pre-given framework, the physicians have the room to make their own decisions. Mr. Hein explains how a structure is imposed on new employees, dictating how work is executed in the department. But after having been in the department for a while, it is definitely possible for all employees to question the departments' structures and to alter work processes.

> „Also, als ich angefangen habe, in der Naturheilkunde z. B. oder in der integrativen Medizin jetzt zu arbeiten, da wurde mir als Neuling, was ja auch klar ist, erst einmal eine Struktur vorgegeben, die heißt: So arbeiten wir hier, und dann und dann macht man das und so und so und so. Ja. Und dass ich schon das Gefühl habe einfach über die Zeit und über ein Vertrauensverhältnis, dass man eben am gleichen Strang zieht so gesehen, dass es dann auch möglich ist, einmal gewisse Strukturen auch einmal in Frage zu stellen oder Arbeitsabläufe, und wenn man das gut argumentiert, dass es dann auch möglich ist, einmal etwas anders zu machen im alltäglichen Ablauf oder so. Und dass das eben_ ja, darüber eben ermöglicht wird, dass man Vertrauen fasst, dass man_ dass das z. B. Oberärzte auch wissen, ich meine es schon gut auch mit dem Team.

Ich bin jetzt nicht irgendjemand, der neu ist und einfach es sich einfach machen will, also_" (Mr. Hein)

As a senior physician, Mr. Fischer has a lot of freedom to make his own decisions. But he also explains the importance of autonomy for the assistant physicians in order to keep everybody satisfied. Inside an established framework, physicians have the room to make their own decisions in patient treatment and work planning.

„Ja. Ich glaube, dass für zufriedene Arbeit ganz_ Es gibt mehrere Dinge, die entscheidend sind. Das eine ist Autonomie. Man muss im gewissen vorgegebenen Rahmen selbst Entscheidungen haben, und ich verlange geradezu von unseren Assistenten, dass sie selbst sich Gedanken machen, sich selbst strukturieren und selbst einen Plan entwerfen. Es muss auch nicht unbedingt meine Lösung sein, er soll nur eine schlüssige präsentieren. [...] Also, es sind ja 15 Patienten da, ich habe gar nicht Zeit, alle 15 Patienten mir vorzuknöpfen. Ich bin darauf angewiesen, dass der Assistent sich selbst einen Plan macht. Von den 15 Patienten mache ich vielleicht zwei oder drei." (Mr. Fischer)

Although all physicians have some room to make their own decisions, degrees of freedom still coincide with the position of doctors in the department. As senior physicians, Mr. Fischer and Mr. Guhl have more opportunity to influence the course of matters than the assistants and specialists. Mr. Fischer says that he has the full freedom to decide how patients should be treated.

„Groß. Als Oberarzt der Station kann ich ja natürlich sagen, wenn ich einen gewissen Plan für den Patienten habe, kann ich mir einfach rauspicken und ihn so behandeln, wie ich mir das vorstelle." (Mr. Fischer)

Just like Mr. Fisher, Mr. Guhl can treat patients in accordance with his ideas and wishes. Furthermore, having been a senior physician in the department for a long time already, he is in a position where he can even steer hospital developments in general.

> „Ich sage einmal, ich kann hier machen, was ich will. Das heißt jetzt nicht, ich mache hier Tabula rasa, sondern die Medizin, die ich machen möchte, die kann ich genau hier umsetzen, und erlebe das einfach hier als ein sehr dynamisches Krankenhaus mit vielen Entwicklungspotentialen und mit Entwicklungen in Richtungen, die mir einfach Spaß machen und wo ich auch selbst sehe, dass ich in einer Position bin, wo ich solche Entwicklungen auch mit steuern kann, die ich mit beeinflussen kann, in welche Richtung das geht." (Mr. Guhl)

Whereas the physicians in the department have some room to change matters within the organizations structural environment, the framework itself is unassailable. Mr. Hein, who previously explained that he sees scope for input, also states that organizational structures are rigid. For physicians who, like himself, do not have the position to make decisions regarding structural change it would be a tough job to alter the long established structural context.

> „Aus meiner Arbeitsposition heraus ist es dann auch wiederum ein bisschen schwierig, weil, es sind einfach_ Ich bin halt Stationsarzt, es ist eigentlich auch klar, dass ich für ein gewisses Zeitintervall nur da bin und jetzt nicht total langfristig. Und es sind Strukturen, die sich etabliert haben, und, ja, das wäre schon_ das wäre schon ein ganzes_ wäre harte Arbeit, glaube ich, so. Und man würde wahrscheinlich gegen feste_ feste Strukturen anrennen erst einmal. Ich habe das am Anfang meiner Zeit ein bisschen überlegt und ein bisschen probiert, und habe dann aber auch gemerkt: Allein geht das nicht, wenn, dann müsste man das als Gemeinschaft irgendwie wollen und machen. Und da ist es dann schwierig, auch das zu organisieren oder das_ weil, die

> Interessen sind halt auch unterschiedlich. Und ich habe es dann aus meiner Position heraus dann irgendwie nicht gemacht. Und_ Ja." (Mr. Hein)

Again, it becomes clear that degrees of freedom for agency depend on the position of the physicians. Not all doctors have the chance to influence the pre-established structural context of their actions. One of these doctors is Ms. Gras who has experienced structural constraint in her wish for part-time work. She started her work in the Internal and Integrative department with an 80% job. After experiencing negative feedback and an information deficit, she decided to raise her hours to a full-time appointment again. Ms. Gras came in what Archer (1982) refers to as a pre-given set of structures in which full-time work is the favorable standard. Her possibilities to change the structural side of the organization are very limited. Although she tried to influence the structural environment with her actions, structural transformation remained out. Instead, Ms. Gras was indirectly forced to comply with the system. Although theoretically speaking, Ms. Gras had a choice to work part-time, practically it was difficult to abide. When I asked her what she could do to alter the current organizational structures, she answered that it is not up to her to make that change. Amendments are initiated and implemented by the management team and the chief physicians.

> Das hängt ja nicht von mir ab, sondern_ Also, ich glaube schon, dass es grundsätzlich immer möglich ist, bestehende Strukturen zu ändern, auf jeden Fall! Das hängt halt von der Zielsetzung oder, ja, von dem Interesse der Geschäftsführung und von den Chefärzten ab. (Ms. Gras)

In the case of Ms. Gras, her position as an agent and her structural environment work constraining in her attempts to work part-time. But transformation not only stayed out due to organizational structures. Also the internalized image of what a doctor should be like made it difficult for Ms. Gras to keep her part-time job. What does this

mean for the influence of feminization? Although the Internal and Integrative Medicine department has always known a feminine work style, an increase in female physicians has occurred here as well. How has this influenced the structure of the department and the practice of medicine?

The physicians in the department connect the feminization process with an increase in the demand for part-time work. However, the implementation of part-time jobs remains difficult due to organizational structures and the personal type of medicine practiced in the department. Although theoretically speaking it is possible, in practice you have to deal with information deficits and a different professional status as a physician. As a result, structural elaboration in this case leads to a reproduction of the system instead of transformation.

When it comes to the practice of medicine, the physicians find it difficult to establish differences between men and women. Although some argue that women have a distinct approach toward patients, gender distinctions in the practice of medicine are rare because of the feminine way of doing medicine. As such, it can be said that structures work enabling in the influence of feminization on the practice of medicine. Female qualities are already an important factor in what they account for as good care, leaving a lot of room for a 'feminine' practice style.

4.3 The Breast Center

The reason for choosing the Breast Center as one of the sections to be studied lies in its interdisciplinary design in which it integrates regular medicine with complementary and alternative medical approaches. The department was started in 2006 with the aim to build a center that focused on all facets of breast cancer including oncology, radiology, plastic surgery and complementary and integrative

medicine as well as research. The department has a ward with 34 beds for in-patients with breast cancer. After residency on the ward, the patients have the option to visit a day clinic facilitated by the physicians of the Complementary and Alternative Medicine section (CAM).

Over the last five years, a small majority of the physicians in the Breast Center has been female. Currently, ten out of sixteen physicians are women. For this study, I interviewed male and female physicians from the conventional medicine as well as the complementary and alternative medicine section.

4.3.1 Organizational Culture

During this study in the Breast Center, I experienced a big difference in organizational structure as well as organizational culture between the conventional medicine section and the CAM section of the Breast Center. The CAM section operates within the larger department but nevertheless has a completely different position, status, structure and culture and holds distinct values and norms than the conventional medicine unit. Although the physicians themselves do not literally refer to the two as different sections within one department, I do make this distinction because it enables me to make a better analysis of the distinct effects of the feminization process on the sections.

Contrary to the physicians in the conventional medicine unit, the physicians in the CAM section all work part-time. They are not primarily responsible for the patients but rather give additive care to the existing treatments such as acupuncture, herb therapy and mind-body medicine. In addition to their work on the ward, they facilitate a day clinic that patients can visit after having been released from the hospital. One of the reasons the section is distinct in its organizational culture is the lack of exchange between CAM and the conventional medicine unit, resulting in a climate of dissociation rather than integration.

„Ich würde wahnsinnig gern mitgehen einmal bei den Stationsärzten in der Senologie oder auch in der Gyn, dass man einfach noch einmal einen anderen_ also, dass man durch die Brille des Anderen guckt und sieht […] Und umgekehrt würde ich mir das auch wünschen, dass Kollegen vielleicht bei uns einmal mitgehen, um zu wissen, was wir eigentlich machen und_ Da ein Austausch wäre sicherlich wünschenswert im Moment. Das ist noch nicht so optimal." (Ms. Doris)

Although Ms. Doris would appreciate to gain a better understanding of the work her colleagues from the conventional medicine section do, interchanges between the two units never take place. The conventional medicine doctors do not actually understand the work the CAM doctors do resulting in misunderstandings about their activities.

"Also, wo wir schon so ein bisschen der Kolibri sind oder_ Ja, die sind schon so ein spezieller, so ein Gefühl hat man manchmal, dass man als Naturheilkundler vielleicht nicht so ganz ernst genommen wird. Ich glaube, so könnte man das formulieren. Kann ich auch verstehen, wenn ich mir den Arbeitstakt angucke und die Arbeitsleistung der Kollegen auf Station, ohne jetzt unsere Leistung schmälern zu wollen, aber es ist einfach ein komplett anderes Arbeiten."(Ms. Doris)

As Ms. Doris explains in the above excerpt, the CAM physicians are perceived by the others as peculiar and are not really integrated into the larger organization. They have somewhat of an outsider position and are not really taken seriously by their colleagues from the conventional medicine section. Ms. Doris explains that she understands the attitude the conventional physicians have toward the CAM physicians since the amount of work and output between the two types of medicine differ substantially. This statement pictures the significant role played by workload in the definition of the good doctor. The status and importance of a doctor increases when more hours are spend at work. Although Ms. Doris elaborates that she does not want to downgrade the work the CAM doctors deliver, the fact that they are not taken seriously by their colleagues from the conventional section shows that their

performance is less valued than that of the others and that the work they do is not seen as 'real' medicine. Being a good and 'real' doctor, thus, not merely relies on the content of care but also on the workload and number of hours spent at work. Ms. Persch, a senior conventional physician, confirms this portrait of a good doctor, stating that being a physician is a calling, not a job, and that this automatically comes with an extensive time input.

> "Also, so dieser zeitliche Aufwand, dass dieses irgendwie_ Arzt sein ist halt kein Beruf, sondern eine Berufung, was halt auch sowohl von den motivierten, engagierten Kollegen, und ich sehe es ja irgendwie auch so, auch kommuniziert und weitergegeben wird, aber was eben halt doch von den Patienten so verlangt wird." (Ms. Persch)

She elaborates that although the high amount of work hours is communicated and passed on by the physicians themselves, it is also the patients who expect the doctors to always be present. Consequently, long hours are a common feature in the department's culture and, as the next paragraph shows, overtime is normal business.

4.3.2 Organizational Structures

4.3.2.1 Work Hours in the Conventional Medicine Section

Mr. Vogel is a doctor of the old days. He is has reached the official age of retirement but has continued his work as a senior physician in the breast center. He still remembers a time where doctors used to work even more than they do today. „Früher haben die Ärzte Überstunden gemacht noch und nöcher, (…)Heute gibt es Arbeitszeitgesetz, es gibt keinen Bedarf mehr an Überstunden, man hat Freizeitausgleich." But although Mr. Vogel says that currently, doctor's work less than they used to a few years ago, most of them still work more hours than they are formally appointed to.

> Bei uns ist es halt in der Tat wieder so, dass diese formellen Arbeitszeiten fast nie eingehalten werden und dass das versucht wird, auszugleichen, aber wenn man ernsthaft einmal nachrechnet, da kommen sicherlich einige Überstunden zusammen, die jetzt nicht wirklich angerechnet werden." (Mr. Vogel)

The extra hours physicians spent at work are seen as normal. It is a taken for granted and given fact that doctors work overtime without getting paid or having the option to balance their extra hours with leave days. It is a generally accepted aspect that comes with the job.

> „Ja, das ist so. Das ist halt die Situation, bei dieser Stellensituation, in Relation zu der Arbeit, die ja ansteht, wenn man jetzt auf dem Standpunkt beharren würde, jetzt ist es vier Uhr, halb Fünf ist hier Feierabend, ich habe den ganzen Tag gearbeitet, der Rest muss halt liegen bleiben, jedenfalls würde es mir dann so gehen, dass man dann mit schlechtem Gewissen nach Hause geht, sonst würde ich ja jeden Tag nachmittags nach Hause gehen, weil ich nur eine Halbtagsstelle habe, aber das kann man irgendwie nicht. Das in so einem Team hier. Ich habe immer diese Patientenpriorität, das ist bei mir so drin in den ganzen 30, 40 Jahren, das kriege ich auch nicht mehr raus." (Mr. Vogel)

For Mr. Vogel, working extra hours is not a problem; overtime has always been part of his job. Being a physician means you cannot just go when your shift is finished and leave the rest of the work to be done for the next day. According to him, patients have priority over work hours. Mr. Vogel explains that he would not go home with a satisfied feeling if he would leave the work to be done for the next day. Although in his explanation he mainly refers to himself, he also uses the word *man* several times, which indicates that this is part of the organizational culture and actually expected of all doctors. Although he is of opinion that an improvement in work-life balance would be good, he also acknowledges that it is illusionary to think that this would

actually happen. A high workload and many work hours are part of being a doctor. For him, it is self-evident that a doctor cannot take private stuff in observance.

> "Und natürlich eine Verbesserung der Work-Life-Balance, weil dann vielleicht alle pünktlich nach Hause kämen, das ist klar, aber das ist illusorisch, das schafft man nicht. […] Ich habe vorhin gesagt, du bist schließlich Arzt, da kannst du nicht auf irgendwelchen privaten Kram oder sonst etwas Rücksicht nehmen." (Mr. Vogel)

The interview excerpts above picture an image of being a physician as a calling. It is not just a job where you work a pre-determined number of hours and then go home again. It is more as a 'way of living' than a job. Being a physician inevitably means that your job comes first and that the rest of your daily life is adjusted to that.

Ms. Persch is doing this 'way of living'. She has fully adapted her life to her job. She left her former position a little over a year ago to come and work in this clinic. She is in her mid-thirties, single and has no children. Growing up in a family of doctors with a father as a surgeon and a mother as a nurse she had quite a good idea of what the profession would be like. Still, in the end, the time investment was different than she expected

> „Also, so dieser zeitliche Aufwand, dass dieses irgendwie_ Arzt sein ist halt kein Beruf, sondern eine Berufung […]." (Ms. Persch)

According to Ms. Persch, the whole idea of work-life balance has not arrived in the minds of doctors yet. Being a doctor is not a job; it is a calling and takes up an incredible amount of time. In her case, her work clearly dictates her private life. On weekdays, she works from 7 AM until 8/10 PM and once a month she works the weekend as well. She admits that this immense workload does not leave much room for a private life saying that: „Theoretisch könnte es ein Privatleben geben. Wenn ich eines hätte, würde mein Arbeitstag wahrscheinlich auch anders aussehen". She tries

to plan some free time in the weekends, but: „meine_ Meine Priorität ist einfach: Klinik“.

Mr. Meister is an assistant physician in his mid-thirties. He is married and has a little child. His wife, who is also a physician, works 80% and takes care of the family. Just like the other physicians, Mr. Meister makes extra hours as well. He has a somewhat ambivalent position when it comes to overtime. On the one hand he states that he would be more satisfied if he his workdays would end earlier and that does not need these extra hours in order to feel like a good doctor. On the other hand, doing surgical operations until late is fine with him because it gives him the feeling that he is doing something important.

> „[…]_ Also, die normale Arbeitszeit würde mir ausreichen, um auch damit glücklich zu sein. Also, ich bräuchte da nicht unbedingt (lacht) wesentlich mehr. Also, ich kann auch aus einzelnen Patientengesprächen viel positives Feedback irgendwo rausholen, also, da brauche ich jetzt nicht kontinuierliche Bestätigung bis 22 Uhr abends, ja? […] Ich meine, es kommt immer wieder vor, wie gesagt, dass man auch einmal bis 22 Uhr im OP steht, dann ist es aber so, dass ich da einfach das Gefühl habe und dass ich da halt auch zu etwas komme, selbst etwas machen kann, sodass das dann für mich nicht so ganz stark ins Gewicht fällt.“ (Mr. Meister)

This excerpt does not only speak out about working hours, but also says something about the special status of surgical jobs. Mr. Meister explains that he does not need extra hours in order to be satisfied neither does he want the acknowledgment of a patient until 10 PM. However, when he has to do surgery until late, it does not bother him, because it gives him the feeling that he can really do something.

Mr. Amon, the chief of the department, acknowledges the immense workload physicians need to deal with. But for him this has never been a problem. He knew before he started his medical studies that a high workload would be part of being a

physicians and it does not bother him to spend so much time at his work. A fulfilling job is of more importance to him than the number of hours he needs to be there.

> „Dass es (Medizin [insert by author]) einen über die Maßen fordert als normal, dass man mehr Stunden arbeitet, was mich aber nie schockiert oder irritiert hat, weil, für mich war wichtiger, dass die Arbeit einen erfüllt anstatt die Stundenanzahl, die man dafür aufwenden muss." (Mr. Amon)

The fulfillment Mr. Amon is talking about has to do with the satisfaction of helping patients to get better which is obviously more important than spending a few hours more or less at work. This asks of the physicians to have a high level of endurance.

> „Es muss ein übergeordnetes Maß gegenüber vielen anderen Berufsgruppen an_ (überlegt) an Leidensfähigkeit da sein, d. h. Dienstbelastungen, Freizeitwert, soziale Kompetenzen nimmt bei fast allen, die im Beruf viel arbeiten, ab. […] Also, es ermattet all' das drum herum. […] Und wenn […] man den Job nicht aus einer hohen inneren Selbst_ oder überhaupt Zufriedenheit, dass der einem ganz viel zurückgibt, zufriedene Patienten, erfolgreiches Team, gute medizinische Qualität, wenn man das alles nicht zurückbekommt, wird es ein Desaster. Das ist, glaube ich, das Problem für die Meisten." (Mr. Amon)

As Mr. Amon explains, being a physician demands a high level of ferventness since it fades out everything beside it. Just like Ms. Persch, he also refers to the profession as being a calling; he even sees this as a prerequisite for a physician. If doctors do not execute their job out of a higher inner self, as he names it, it will end in a disaster for them.

For the physicians in the Breast Center, work takes up a lot of time therewith affecting their private lives. Not only are working life and private life clearly segregated, as in the division of labor, but work time also dictates private life, not the other way around. As most of these physicians state, there is not much room left for

leisure time. With almost all doctors making extra hours, there can hardly be spoken of a work-life balance. But instead of trying to alter this, the physicians seem to accept it as an inevitable part of their profession. Overtime has become a taken for granted aspect of being a doctor. Acker (1990) refers to this phenomenon as organizational logic; the undescribed rule that you do not go home when your shift ends, but that you stay until work is finished and the patients are taken care of. Herewith, the image of a good doctor resembles Acker's unencumbered neutral worker that has no life outside the workplace. Mr. Vogel underlines this picture when he says: „[…] du bist schließlich Arzt, da kannst du nicht auf irgendwelchen privaten Kram oder sonst etwas Rücksicht nehmen."

Long work hours are a not only a taken for granted part of the job. It also serves in the image building of a good doctor. Being a physician is a calling and your work needs your undivided attention. Every other aspect of your life comes second. Not serving this standard means not sufficing the image of a good doctor. As the excerpts at the start of this paragraph about the relationship between CAM physicians and their colleagues from the conventional medical section show, not sufficing the image of a good doctor means not being taken seriously. The fact that Ms. Doris explains she understands this shows how she herself has internalized the image of a good doctor and not meeting these standards makes it acceptable for her not be seen as a 'real' physician.

4.3.2.2 Part-Time Work in the CAM Section

Whereas the majority of the physicians in the conventional section of the Breast Center work full-time, most of the CAM physicians work part-time. Even the senior physician of the CAM unit, Ms. Schmidt, has filled her position many times with a part-time job. Ms. Schmidt has two children of six and eight years old and is pregnant with her third at the time of the interview. She has been working full-time since a few

years, but after giving birth to her third child, she will reduce her hours again. Because of her children, she starts work at 7.30 AM and leaves again at 5 PM. Her stepchildren take her kids from school and childcare and she has a housekeeper who comes six hours a week to do the cleaning. But regardless of all this, work is too much for her, especially since she is pregnant. That is why she has decided to work part-time after having her baby. She will then share her senior position with a female colleague who is a mother as well. Ms. Schmidt's work hours are clearly much more flexible than that of her colleagues in the conventional medical section. The reason that she can reduce her hours and share a senior position lies in the fact that she works in the CAM section. Because complementary care is additional to the conventional medicine that the center provides its patients, there is no need for the CAM physicians to run a ward or to do weekend and night shifts. It is, therewith, a lot easier for the physicians to have part-time jobs.

Ms. Doris is very satisfied that she can work part-time. It gives her the opportunity to spend time with her daughter. Since everybody in her section works part-time, she does not have the feeling that this is negatively influencing her position in the department. This is very different from the experiences she had in the department of Integrative and Internal Medicine, where she used to work.

> "Also, ich hatte_ Ich habe im letzten Jahr drüben im ‚Knappi' gearbeitet und hatte da auch, also, die gleiche Stelle sozusagen, von montags bis donnerstags, die gleiche Zeit auch, war dort aber eingebunden in ein Team, wo alle voll arbeiten. Und hier ist es genau anders. Hier arbeiten fast alle Teilzeit, also, hier kenne ich kaum einen_ Also, hier gibt es eigentlich niemanden bei uns in der Naturheilkunde, der von montags bis freitags Vollzeit da ist. Insofern finde ich diesen Vergleich ganz interessant. Drüben im ‚Knappi' habe ich eher das Gefühl gehabt: Man kann nur bestimmte Aufgaben machen, weil man ja auch nur halbtags da ist, z. B. kann ich drüben keine Stationsleitung haben oder ich kann keine eigene Station haben, keine eigenen Patienten betreuen, weil das einfach mit der halben Stelle nicht machbar ist. Und hier ist es so, dass ich mit der

halben Stelle trotzdem voll integriert bin, also, dass ich einfach merke: Hier habe ich trotzdem ‚meine' Patientinnen, die ich jede Woche wiedersehe und wo ich den Verlauf beurteilen kann. Und das macht es hier wirklich sehr spannend. Also, hier habe ich nicht das Gefühl, dass eine halbe Stelle sich negativ auf mein Berufserleben auswirkt." (Ms. Doris)

So in the CAM department, she had the feeling that she only got appointed certain tasks because she did not work full hours. Here, because everybody works part-time, she feels entirely integrated. As this excerpts shows, being able to work part-time depends on the organizational structures. Because the department of Internal and Integrative Medicine is organized in a different way, part-time work is harder to achieve and comes at high cost. Here, because the physicians are only appointed the task to deliver additional care, the costs of working part-time are not so high.

But the CAM section also has a certain framework that comes with norms and standards imposed on the employees. Ms. Ebert is a mother of two little children. Because she is the primary caretaker in the family, she works Thursdays and Fridays from 9:30 AM to 3 PM. Due to the little amount of hours she spends at work, she often experiences an information deficit.

"Ich bekomme Informationen nicht gut, ich erfahre die Sachen immer_ wenn irgendwie Neuerungen sind, und hier wird ständig etwas erneuert, ganz_ Kleinigkeiten, und die erfahre ich nicht. Und gar nicht. Also, es kommt gar keine Information an. Und das erfahre ich immer erst, wenn ich etwas dann_ was weiß ich_ falsch gemacht habe. Wenn ich etwas gemacht habe, wie es immer gemacht wird, dass dann irgendjemand ankommt und sagt, ‚Nee, aber heute ist es doch so', 'ne, also, ich erfahre das wirklich nur dann über so eine negative Rückmeldung. Das frustriert dann immer, weil man ja nicht da ist. Klar. Das versucht man dann immer so aufzufangen irgendwie. Das ist stressig! Schon, ja, ja. Und es ist natürlich auch so diese_ Ich bin ja auch schon mehrfach gefragt worden, ob ich nicht aufstocken kann, und_ Würde ich gerne, aber es

funktioniert nicht. Ich kann nicht mehr arbeiten, ich wüsste nicht wie und wo." (Ms. Ebert)

Since Ms. Ebert works so little hours, she often does not receive any information on renewals in the department until she does something wrong. It is only then that she comes to know that things have been changed. The difficulty of finding out on new procedures and the negative feedback that comes with it are frustrating for Ms. Ebert. As this excerpt shows, although part-time work is possible in the CAM section of the Breast Center, for Ms. Ebert this means paying the price of an information deficit and negative feedback.

4.3.2.3 Work-Life Balance

As I have elaborated on in paragraph 4.3.2.1 work-life balance in the conventional medical unit has not been integrated in neither its culture, nor its structure. And even though the women in the CAM section work part-time, for them it also remains an issue to combine work and private life. Ms. Ebert calls it a balance act, and Ms. Doris has difficulties bringing together work and motherhood as well. Even though she is happy with her work hours, she is still some sort of disappointed with the little time she can spend with her daughter. Her situation is exemplary for the position many female physicians with children find themselves in. As the next excerpt shows, even part-time work does not completely solve the issue of combining work with family matters. For Ms. Doris, this meant that she had to adjust her ideas on motherhood.

„(lacht) Das ist zuweilen schon schwierig. Ich habe mir das immer ganz schön ausgemalt, dass man_ hah, wenn man dann ein Kind hat, dann_ na ja, arbeitest du halt vormittags, und dann ist nachmittags Zeit für das Kind. Und das ist so, dass ich, je nachdem, wann ich hier herauskomme, ich schon im Stau auch stehe, sodass ich eben jetzt meistens gegen halb Vier dann doch erst Pia abholen kann. Und dann verbringen

wir schon ein paar Stündchen miteinander, aber an manchen Tagen ist es schon auch so, dass sie dann einfach müde und platt ist. Und dass man dann hier den_ die unangenehmeren Stunden am Tag mit dem eigenen Kind hat, und die Stunden, wo das Kind eigentlich wach ist, also, vormittags, und wo halt einfach viel passiert, die erlebt man dann ja nicht unbedingt mit dem eigenen Kind. Das habe ich zuweilen auch durchaus als ein bisschen traurig empfunden. Das klappt nicht so reibungslos, glaube ich, wie ich mir das ursprünglich einmal ausgedacht habe. Generell habe ich aber das Gefühl, dass mit einer halben Stelle das schon eher geht als wenn ich jetzt eine Dreiviertel- oder gar eine volle Stelle hätte. Also, das wäre sicherlich etwas, was ich zum jetzigen Zeitpunkt mit einem kleinen Kind nicht_ nicht will. Was ich schon schwierig finde, sind natürlich dann auch Fortbildungen, die man am Wochenende hat. Also, das, was ich bis jetzt beschrieben habe, ist ja eigentlich eine normale Woche. Aber das, was dazu kommt, sind Supervisionstermine oder sind so wie jetzt einmal Verabschiedungen, die wir im Team haben, oder auch einmal Besprechungen, die außerhalb der Arbeitszeit liegen, oder eben Seminare, Wochenendfortbildungsgeschichten, da ist es schon so, dass das, na ja, zwölf Wochenenden sicherlich sind im Jahr. Und dazu halt noch diverse Termine dann einmal unter der Woche. Und_ Oder so wie jetzt auch mit Prüfungen und Prüfungsvorbereitungen. Das ist jetzt sicherlich auch eine Ausnahmesituation, aber es ist doch mehr als jetzt eine reine halbe Stelle.“ (Ms. Doris)

Again, it is emphasized that being a physician is more than a job. As Ms. Doris explains, when you choose this profession, there comes more to the job than just work hours. Many weekends are filled with trainings and seminars, and team-meetings also take place outside official work hours. This leaves even less room for doctors like her to spend time with their families.

4.3.3 Organizational Culture and Structure

The conventional medical section of the Breast Center knows a culture in which overtime has become a normal factor of daily work life. Part of this culture is the image of a good doctor as an unencumbered worker who is there for his/her patients. Herewith, the prevalent image of a good doctor resembles Acker's abstract worker who has no body and no obligations outside the workplace (Acker, 1990). A good doctor, just like Acker's abstract worker, has to be work-oriented and thus full-time available. Commitment to the job is required and defined in terms of behavior that indicates the primacy of work over demands of private life. This means putting work first (Acker, 1990). Ms. Persch literally refers to this when she states that being a doctor is a calling and that her work in the clinic has priority over her personal demands. In order to fit this image of the good doctor, individuals should not have too many obligations outside the workplace. For women, it is very difficult to meet these standards since they are in many cases still the ones who take care of the family.

In the CAM unit, part-time work is allowed but this immediately gives the unit a different status within the larger department. The section leaves much room for work-life balance because of the various part-time options it offers. Still, the organizational structures are built up in such a way that in some cases, like Ms. Ebert's, not all physicians can attend meetings and be part of decision-making processes, resulting in an information deficit and negative feedback.

4.3.4 The Feminization Process in the Breast Center

Over the last few years, the Breast Center has experienced a noticeable numerical feminization. But women have not always made up most of the physicians in gynecology. Mr. Vogel, who has been a gynecologist for more than 40 years, has

worked in several gynecology departments and can still remember the first time he had women in his team of physicians.

> „[…]da hatten wir erstmals zwei Frauen im Team. Das galt als ganz spektakulär. ‚Mensch, wir haben Frauen im Team. Wir haben etwas total Besonderes.' Das muss so 1970 gewesen sein, 1969/1970. […] Das war wohl auch so, dass komplett keine Männer gefunden wurden. […]Es gab Zeiten, wo man_ Ärzte auch schlecht zu finden waren, da ging man sowieso schon einmal Kompromisse ein […] Und das war eine so positive Erfahrung, auch Frauen im Team zu haben, als dann später, da war ich damals Oberarzt, als ich damals Chefarzt wurde, habe ich gesagt, ‚Du musst unbedingt auch Frauen im Team haben'. Das, was damals noch die Ausnahme war, habe ich da als positiv erfahren und wollte unbedingt bei der ganzen Männergeschichte ein, zwei Frauen im Team haben, weil ich das so positiv erlebt hatte." (Mr. Vogel)

The first time Mr. Vogel had the experience of working with women in his team was in 1970. In those days, it was still extraordinary to have female physicians. As he explains, the reason for choosing women was mainly because there were no men available, not because of a deliberate choice for female physicians. The experience of having female physicians in his team had such a positive effect on Mr. Vogel, that he decided from that point on to always have one or two women in his team. When I asked him what exactly it was that stroke him so positively he answered that women have such a good influence on the team spirit, or better said, on the behavior of men.

> „Ach, wissen Sie, Männer sind doch so ziemlich testosterondominiert, 'ne. Da gibt es schon einmal Ellenbogen, Rechthaberei und man möchte die Operation selbst machen und nicht der andere usw., und bei Frauen, da ist man_ da wirkt der Geschlechtsunterschied natürlich schon im Umgang, man möchte da ein bisschen auch der Gentleman sein und so." (Mr. Vogel)

So Mr. Vogel did not decide to have female physicians in his team because of their medical skills or their possible distinct perspective on care, but because of their positive effect on the behavior of the male physicians. That is why he states to only want to have one or two women to join the men's party. As such, he would have enough women to make the men function better, but not so many as for them to really have a big influence on medical matters.

Meanwhile, times have changed. Female physicians are no longer a rare exception but have gained a central position in the medical world. But how exactly has this influenced medicine? I asked my participants how they experience the feminization process and how they see it has influenced medicine on a structural as well as a practical level.

4.3.4.1 Feminization of Structure

One of the opinions in the discussion on the feminization of medicine is that an increase in female physicians will augment the demand for part-time work, therewith changing the work structures in the medical institutions. Ms. Ebert refers to this phenomenon in the interview. She thinks that feminization leads to more part-time work and an intensification of family-friendly work opportunities.

> „Und ansonsten sieht man das jetzt schon häufiger, dass man auch Oberärztinnen hat, und dass das auch viel mehr auftritt, so diese Familienproblematik, dass man doch viel mehr Kolleginnen hat, die auch in Teilzeit arbeiten, und die Familie haben, was sonst nie ein Thema war." (Mr. Ebert)

Mr. Vogel shares the opinion that women have influenced ideas on work hours. He explains how in former days, physicians used to make an infinite amount of hours.

Nowadays, with the arrival of women in the profession, ideas on work-life balance have started to change.

> „Man hat ein ganz anderes Lebensbild, und das hat auch mit Frauen zu tun, die natürlich in der Familie, wenn vielleicht der Partner auch noch arbeitet, weiter auch die Frauenrolle in der Familie teilweise übernehmen wollen oder behalten wollen, zumal wenn Kinder da sind, und da geht es nicht um_ da wollen die keine Überstunden haben und auch möglichst keine Nachtdienste und auch möglichst vielleicht gar keine Karriere, da geht es um ziemlich arbeiten nach Uhr und so […]“ (Mr. Vogel)

According to Mr. Vogel, contemporary doctors no longer have the wish to work extra hours, they want leisure time. He says that this has to do with the fact that ever more women join the workforce. Since women have the primary responsibility for the family, they are not interested in working extra hours. As a matter of fact, they often do not want to have a career in general. Just like is the case in the other departments, in the Breast Center, having a career is equalized with a high amount of work hours and thus as incompatible with family caretaking.

According to Mr. Vogel, as a result of the feminization process, the focus has shifted from extreme long work hours to working by the clock. In my opinion, though, the physicians who work in the in the Breast Center, do not give the idea of only wanting to work by the clock at all. All of the conventional medicine physicians I interviewed, including the women, make extra hours and all of them see this as a ‘normal’ aspect of their work. Later on in the interview, Mr. Vogel slightly changes his perspective, saying that in his department, it is hardly ever the case that formal working hours are observed and that all doctors make extra hours.

What this case exemplifies is that even though the prevalent idea is that women will work less hours, in many instances this is not the case. And even if women demanded less work hours, flexible work structures that would allow for more free time are not yet realized in the department.

Ms. Schmidt emphasizes the problematic lack of family-friendly policies. She expects a high demand of part-time work as well, but also underlines that more flexible structures need to be found and implemented in order to accommodate these wishes.

> „und das bedeutet natürlich auch, […] gerade wenn Frauen Kinder haben, es mehr Teilzeitstellen notwendig sind, […] Es ist natürlich auch schwieriger geworden durch Schwangerschaft, Mutterschutz. Das muss ja, wenn eine Frau dann ein Kind kriegt, müssen da ja ein paar Monate überbrückt werden, was dann auf das ganze Team eigentlich an Mehrarbeit anfällt, und da braucht man sicher flexiblere Strukturen als sie bisher üblich sind. Normal ist ja eine Vollzeitstelle mit Diensten und Wochenendarbeit, und das geht natürlich mit Kindern und Familie in der Weise, wie es bisher gehandhabt wurde, nicht." (Ms. Schmidt)

Mr. Amon shares Ms. Schmidt's concern with regard to family policies. When I asked him about his opinion on the feminization of medicine, he said that he experiences the feminization of medicine as something very positive and that he finds it pleasant to have women in his team. Furthermore, female doctors have a good work attitude and deliver top quality care, in some cases, their medical skills are even better than those of their male colleagues. „Ich finde den Ansporn an die Qualität, die sie zeigen, ist teilweise höher als bei Männern", Mr. Amon states. He almost sounds surprised that women deliver such good quality, as if he had not expected them to meet and in some cases even exceed the standard set by their male coworkers. Where he does see problems, however, is in the compatibility of work and family life.

> „Das Problem, was wir haben, was ich sehe, was wir haben, ist natürlich, dass es immer noch die Mutter-Kind-Rolle gibt, dass wir nicht genügend Strukturen haben in Deutschland wie in anderen Ländern, wie in Skandinavien oder sonst was, wo ich höre, dass die Frauen eben nach acht oder zwölf Wochen wieder in den Arbeitsprozess einsteigen, und dass es hier Frauen gibt, die sagen, ‚Ich bin jetzt gerade_', weil, man

wird nicht gebremst, wenn man mitten in der Ausbildung ist und so nach dem Motto, ‚Nee, wer weiß, Sie werden schwanger, dann lassen Sie das einmal, ich bilde jetzt den aus', sondern sie fühlen für sich selbst, weil sie dann so lange aussteigen, dass natürlich die anderen dann, die mit ihr eben gestartet sind, an ihnen vorbeiziehen, ja, operativ, in der Patientenversorgung, in der_ was weiß ich, Oberarzt werden usw." (Mr. Amon)

In the excerpt above, Mr. Amon explains how in countries in Scandinavia, it is much more likely for women to reenter the workforce only eight to twelve weeks after giving birth. In Germany, this is not the case. There are not sufficient structures in place to support a quick return to work. When women leave their jobs due to family matters, this has a high influence on the course of training and work experience. When they return to their jobs after several months or sometimes years, they feel like they have missed out on possible career options. According to Mr. Amon, this causes for physicians with children to become unsatisfied. He places the problem of work-life balance with the women themselves and in Germany's (lack of) family policies, not in the way his department is structured. On the other hand, he also sees it as a responsibility of modern day businesses to provide in better childcare solutions. He explains that the hospital is working together with the Human Resource Management department to look at possibilities to improve child care facilities for their employees, therewith giving women the opportunity to decide for themselves how long they want to stay at home, when they want to start again, and how many hours they want to work.

„Das organisieren die Frauen sich selbst, dass sie sagen, ‚Ich mache die und die_ so viele Stellen, oder ich mache nur eine 75-%-Stelle oder ich bleibe ein oder zwei Jahre zu Hause'. Ein Wiedereinstieg wird immer ermöglicht in der Situation. Aber auch die Kenntnis dabei. Ich denke, es ist für ein modernes Unternehmen_ mittlerweile gehört es dazu, die Kinderbetreuung mit anzubieten. Und da ist das Unternehmen hier dabei, auch mit der Personalabteilung ist es vorrangig deren Aufgabe zu gucken, dass_ dass man das verbessert, dass man den Frauen einfach dort die Möglichkeit gibt, in den

Arbeitsprozess_ selbst zu entscheiden, ob sie_ wie lange sie zu Hause bleiben möchten und wie sie das insgesamt meistern möchten." (Mr. Amon)

Although Mr. Amon wants to improve the possibilities to reconcile work and family life, he is also of opinion that women actually do not want to stay at home to take care of their children but rather want to go back to work. He feels that women should change their opinions on motherhood and not feel guilty when they are not there all the time to take care of the family.

„Ich glaube, es geht nicht darum, dass die Frauen gern zu Hause bleiben wollen, sie müssen eine Chance_ Sie brauchen es sofort. So. Und sie müssen nicht immer das Gefühl haben, dass sie denken, ‚Ich habe jetzt irgendetwas_ Ich arbeite zwar hier, aber muss nur ein schlechtes Gewissen haben, weil ich das und das alles vernachlässige. Und das wird auch den Ehen gut tun, glaube ich." (Mr. Amon)

The next excerpt explicates Mr. Amon's ideas on motherhood and women who choose to stay at home. He speaks very denigrating about women who take childrearing as their primary task. Not only because it is a waste of their intelligence and education, but also because he does not value it as proper work, especially in comparison to a "real" job outside the home.

„_ Also, was ist das für eine Rolle und für ein Bild, ja? Sie machen Abitur, Sie studieren, Sie sind mindestens so intelligent wie Ihr Mann, und dann bleiben Sie zwei, drei Jahre zu Hause und unterhalten sich nur noch über den Babybrei, das Kochen, die Windeln, über die gemeinsame Schwimmgruppe, Babygruppe da, Spielplatzabenteuer mit dem, anstatt nach Hause zu kommen und mindestens nach einem geregelten Halbtagsjob oder sonst irgendwie zu sagen, ‚Also, ich hatte heute <u>das</u> Problem, ich habe das operativ <u>so</u> gelöst' oder ‚Wir haben das_'. Ist ja eine ganz andere Kommunikationsform auch im_ in der Partnerschaft, wenn man sich da gleich_ Also, finde ich." (Mr. Amon)

So what exactly is Mr. Amon trying to say here? He starts by saying that the problem lies in the lack of structures that Germany has when it comes to the combination of work and family. In Scandinavia, women go back after eight to twelve weeks, whereas in Germany, women stay out of the workforce for a much longer time, feeling bad afterwards because they have not prospered in their work as much as their colleagues. Mr. Amon is of opinion that the hospital should provide in better childcare facilities, because, as he explains, women do not want to stay at home but do not see other possibilities because of the lack of childcare. But there is more to the matter. Mr. Amon has a very strong opinion on motherhood, stating that women should go back to work again as soon as possible. Women should not have a bad conscious because they work instead of being at home with the children. He then continues his argument elaborating that actually he finds it ridiculous that women who have had an education decide to stay at home for two or three years, only talking about babies instead of pursuing a career in medicine. According to him, it is much better to go back to work as soon as possible and childcare can facilitate this.

With his statements on work-life balance Mr. Amon's intention is not to change organizational culture and structures in order for women (and men as well) to better be able to combine a career in medicine with family life, but to provide child care facilities to enable women to join the workforce full-time again as soon as possible. Instead of trying to alter departmental structures to come towards the needs of physicians responsible for family caretaking, or change opinions on the division of labor and what it takes to make a career in medicine, Mr. Amon places the issues surrounding the compatibility of work and family live with the women themselves and the lack of childcare facilities in Germany in general. Furthermore, although earlier in the interview Mr. Amon explained that women should figure out themselves how many hours they want to work, when I ask him directly about the possibilities of part-time work, he explains that this is not possible within the current structures.

„Das ist schwierig in der Situation, weil die Arbeitsbelastung sehr hoch ist und weil man dann viele Patienten nicht sieht, das_ Die Modelle, die wir hatten bisher oder mit denen, wo wir es hatten, ist insofern so_ das muss man auch ehrlicherweise sagen, das haben wir nicht geschafft, dort das gut zu integrieren, weil die Arbeitsbelastung sehr hoch ist und natürlich dann irgendwann die Frauen auch ein schlechtes Gewissen hatten und gesagt haben, ‚Ja, ich gehe dann einmal um 14 Uhr, die Hälfte der Arbeit ist noch nicht gemacht, und alle anderen, die noch kein Kind haben, werden sowieso wieder dafür bestraft und arbeiten doppelt so lange, bis die Arbeit geschafft ist, und gehen um 20 Uhr nach Hause, aber ich kann nicht länger bleiben.' So. Also, das hat auch ein gewisses Spannungsfeld." (Mr. Amon)

As this excerpt shows, part-time work just does not fit in the conventional medicine unit. As Mr. Amon explains, it will lead to tensions between the physicians, if those with families go home at 2 PM, leaving the rest of the work to be done by the other physicians. So although he mentioned before that women should get the opportunity to decide for themselves when they want to return to work and how they want to manage that, he actually feels that women should start working again as soon as possible. His ideas bear similarities with what Acker (1990) calls the unencumbered worker who has no obligations outside the workplace. Mr. Amon wants to take the burden of childcare so women can work without having to bother about their children. He therewith does not take into account that women maybe do not want to be full-time involved in work but rather spend time with their family.

4.3.4.2 Feminization of Practice

In addition to the question of how the increase of female physicians has influenced organizational structures in the Breast Center, I also asked my participants about the effects of the feminization process on the practice of medicine. Some of them said that

women have more empathy and are more emotional than men are. Others do not see any gender differences in practice style at all.

> „Das ist schwierig. Kann ich so pauschal auch gar nicht beantworten. Also, jetzt, in der normalen Schulmedizin könnte ich es gar nicht beantworten. In der Naturheilkunde finde ich_ glaube ich schon, weil das eine ganz andere Herangehensweise ist auch in der Naturheilkunde. Ja, glaube ich schon, dass da eine Femi_ […] (überlegt) Schon, was man als Soft Skills so bezeichnet, dass man einfach vielleicht etwas empathischer den Patienten gegenübertritt und_“ (Ms. Ebert)

Ms. Ebert says that she finds it difficult to give a general answer on this question. But she has the feeling that in the CAM department, feminine characteristics are more present. It is not clear, though, how this relates to a feminization exactly since CAM has always been a place where soft skills have been highly valued.

Ms. Schmidt is careful about generalizing when it comes to gender differences as well. She explains that there does not have to be a difference between men and women in practice style, but that women indeed have more emotional competence.

> „Ich habe gerade überlegt, ob Frauen empathischer sind als Männer. Das muss nicht sein. Aber Frauen bringen da schon noch einmal eine andere emotionale Komponente rein, die wahrscheinlich auch einem Patienten gut tut, an manchen Punkten. Vielleicht auch einmal etwas Mütterliches, so ein bisschen mehr Fürsorglicheres, das denke ich schon.“ (Ms. Schmidt)

So although Ms. Schmidt hesitates to mention gender differences on the one hand, her statements do link the competences of female doctors to the stereotypical image of women as being emotional and caring. Interestingly, when I asked Ms. Schmidt about the influence of feminization on the actual practice of medicine, she stated that the quality of medical care depends on the chief of the department more than on

gender. There are clear guidelines on how medical care should be provided, and these go for male as well as female physicians. As such, she argues, the feminization process has not engendered much change in the practicing of medicine in the department.

> „Das ist ganz schwer zu sagen, ob sich da die Qualität verändert hat durch. Das finde ich schwer zu sagen. Ich glaube, dass die Qualität in der Versorgung sehr auch von Chefarzt und den Anforderungen tatsächlich abhängt, was der für eine Erwartungshaltung hat. Fast mehr, als davon, ob eine Frau oder ein Mann die dann erfüllt. Wenn da die Vorgaben klar sind, was zu leisten ist, dann gilt das sowohl für die Ärztinnen als auch für die Ärzte, so dass ich nicht den Eindruck habe, dass sich da so viel geändert hat. Ich kann mich aber täuschen." (Ms. Schmidt)

Ms. Doris has a somewhat different opinion on the matter. She directly links feminization to her encounters with women advancing to high level positions. She has experienced women who made it to the top showing very masculine behavior and basically imitate men, which does not leave much room for feminine skills. It is her wish for women to be able to express their femininity inside the workplace without being labelled as too soft or emotional. She wants women to stand to their feminine side and therewith practice a different form of professionalism.

> „Ich finde, bisher hatten wir es oft so, dass die Frauen an die Spitze gekommen sind, die sehr_ also, die ein männliches Verhalten hatten und die im Grunde Männer nachgeahmt haben. […] Und mein Wunsch wäre, dass wir Frauen sein dürfen und trotzdem unseren Beruf ausüben dürfen, ohne als zu weich oder zu weiblich oder zu emotional abgestempelt zu werden. Also, mein Wunsch wäre, dass wir Frauen uns trauen, zu unserem Frausein zu stehen und zu einer anderen Form der Berufsausübung und damit, wenn wir das schaffen und uns eben nicht vermännlichen in unserem Auftreten, also, wenn wir Frau sein können, dann glaube ich, dass das auch eine Medizin und damit auch eine Gesellschaft verändert." (Ms. Doris)

Ms. Doris principally explains that feminization so far has hardly engendered any change. She argues that women are softer and more emotional than men, but that these characteristics are negatively labelled in the profession. She also says that women do not have the room to practice a different kind of medicine. As a result women masculinize and adapt to the current system.

There are also physicians in the department with another perspective on the influence of the increase of female physicians on the profession. Mr. Meister, for example, does not see how the feminization has gravely changed medicine. The only aspect in which women doctors differ from their male colleagues is in their communication style. He feels that interaction between female physicians and female patients is more understanding than between male physicians and female patients.

> „Aber ich habe prinzipiell schon das Gefühl, dass bei Frauen, vor allem jetzt in der Frauenheilkunde, wo das praktisch immer Frauen sind, die Patienten sind, dass da der_ die Kommunikation zwischen Frau und Frau teilweise besser ist oder auch verständnisvoller vielleicht ist als zwischen Mann und Frau." (Mr. Meister)

I think this might have to do with the fact that, more than with other diseases, breast cancer is a very intimate topic to talk about. Since men cannot experience what it is like to have breast cancer, it could be easier for female physicians to relate to the patients than it is for their male colleagues. But when it comes to actual changes in the practice of medicine, Mr. Meister is of opinion that gender has no influence on this. Mr. Vogel is of the same opinion as Mr. Meister, but his view is even stronger. When I asked him about the effects of feminization on the practice of medicine, he responded that it could never be the case that gender influences medicine and even went as far as stating that this would be a disaster.

> „In der Praxis? (überlegt) Ja, ich meine, bezüglich von irgendwelchen Therapieentscheidungen usw. kann das ja keinen Einfluss haben, das wäre ja völlig

> verrückt. weil die Therapien und solche Dinge, das wäre ja fatal, wenn sich das durch die Feminisierung ändern würde, das wäre ja verrückt. Das darf es ja nicht sein. Da müssten ja Fakten entscheiden, was therapeutisch jetzt gemacht wird mit den Patienten […]."(Mr. Vogel)

Mr. Vogel states that gender can and should never influence medical therapies. Doctors have to be completely objective and their decisions and actions should be structured by pre-given facts and guidelines, not by personal choices. In other words: facts and guidelines decide which therapies patients receive, not human beings. This sketches an image of a doctor as an abstract phenomenon that does not leave room for gender differences, bodily experiences and personal beliefs. As Mr. Vogel explains: „Also, eigentlich müsste man vom Beruf her von beiden Geschlechtern das Gleiche erwarten."

Although the breast center experiences a clear numerical feminization, its effects are everything but clear and straightforward. Just like the general discussion on the feminization process suggests, the physicians of the department expect an increase in the demand for part-time work. But there is a difference between the general discourse and the actual situation within the center. Mr. Vogel, for example, argues that physicians do not want to work extra hours anymore, but then continues saying that the physicians in the department still work overtime. Besides, even when part-time work will be demanded more often due to an increase in female physicians, family-friendly work models have not yet been implemented in the conventional medicine section. Mr. Amon acknowledges the issues women with children face, but situates the problem in the lack of childcare and the women themselves. So although the expectations from the feminization process are an increase in part-time work and family-friendly organizational structures, actual transformation has not taken place yet. In the CAM section, though, part-time work has always been part and parcel of the organization.

The influence of feminization on the practice of medicine is a whole different matter. Most of the physicians in the department only see an influence when it comes to communication, either within the team or between female doctors and female patients. But when it comes to the practice of medicine, the physicians do not see any changes. As Ms. Schmidt and Mr. Vogel explain, there are clear guidelines that decide the content and quality of care, and gender does not play a role in this. Ms. Doris is of a different opinion, she thinks that there is a feminine way of working that differs from a masculine working style. However, traditional female qualities are negatively labelled and the medical institution does not leave room for women to express their feminine work style.

In the discussion on feminization, gender is in some cases made explicit, and is neutralized in others. Ms. Schmidt and Mr. Vogel, for example, do not see gender differences when it comes to medical actions or professionalism itself, but when it comes to communication between the genders or between female physicians and patients, gender differences are allowed. Mr. Vogel explicates that he expects men and women to execute their work in the same manner, but he does want women in his team because they positively influence the ambiance and communication within the department. Here, he literally refers to the gender component saying: „[…]da wirkt der Geschlechtsunterschied natürlich schon im Umgang." Ms. Schmidt, on her turn, explains that the way medicine is practiced strongly depends on the guidelines and the chief of the department and that gender does not play a role in this. „Wenn da die Vorgaben klar sind, was zu leisten ist, dann gilt das sowohl für die Ärztinnen als auch für die Ärzte, so dass ich nicht den Eindruck habe, dass sich da so viel geändert hat." On the other hand, when asked about the differences between male and female physicians, she states that women have something motherly and carefulness in their approach to patients. In these cases, gender is being made explicit when it is conforms general gender stereotypes.

4.3.4.3 Stereotypes and Gender Behavior

Just like in the other departments, the research I conducted on stereotypes in the Breast Center shows how characteristics like caring, communication skills and compassion are seen by the physicians as typical female, whereas traits such as analytical, goal-oriented and assertiveness are perceived as being masculine. When it comes to expressing gender distinct behavior on the work floor, differences between men and women are made explicit when consonant with these stereotypes but neutralized when it comes to the medical profession or professionalism in general. So on the one hand, the increasing presence of women in the team is rejoiced because they have a good effect on the general ambiance in the group. The female physicians in the department are also allowed to bring in an emotional component and communicative qualities, because it is consonant with female stereotypes and the traditional image of women as caretakers. But as soon as it comes to the influence of the increase of women doctors on the content and practice of care, and therewith on the professional side of it, gender can and should not have an effect.

4.3.4.4 Vertical Segregation

Although a clear numerical feminization is visible within the department on a horizontal plane, vertical segregation is still present. The chief of the department is a man and so are the senior physicians. Ms. Schmidt, the senior physician of the CAM section, is the exception to the rule. Why are so few women working on high level positions? According to Mr. Vogel, it is only a matter of time before the number of female chief physicians will have increased.

> „Das kommt jetzt demnächst. Also, das wird in fünf Jahren, zehn Jahren wird der Anteil für Frauen an Chefärzten deutlich höher sein." (Mr. Vogel)

However, none of the women I interviewed want to become chief physician, the main reason being the incompatibility of family and a career. Even Ms. Persch, who initially came to the department to prepare herself for a chief position, decided to abandon the plan.

> "Aus dem Grund bin ich hierher gekommen (lacht), um sozusagen noch einmal das, was mir fehlt, oder um mich noch einmal darauf vorzubereiten, um die Position erfüllen zu können, was ich mir unter einer guten Chefärztin vorstellen würde, also, um da eben meine Grundlage zu schaffen. (sucht nach Worten) Ich bin mir da aber nicht mehr ganz sicher. Also, ich weiß es nicht. Es ist vielleicht auch jetzt ein bisschen früh, aber letztendlich ist dieses_ dieses Brustzentrum, diese Klinik ist für mich sozusagen ein optimales Brustzentrum, so von dem, was ich für die Patienten habe, was ich an Therapie anbieten kann, wie das_ wie man das gestalten kann für Patienten. Und ich glaube nicht, dass ich bereit bin, das zu leisten, was unser Chef hier leistet." (Ms. Persch)

The reason Ms. Persch gives for the renunciation of her original idea to become a chief physician, is that she is simply not willing to fulfill the demands that come with such a position. But she also states that even if women want to become a chief physician, it is incredibly difficult for them since the decision for such a position often coincides with a time where women ground a family.

> „Ja, das ist ja auch wieder_ Also, Frauen sind nun einmal auch so, dass sie die Rolle des Kinderkriegens übernehmen (lacht), und dass da_ müssen auch einfach aus biologischen Gründen, und damit eben halt auch Fehlzeiten entstehen. Und ich glaube, das ist einfach schwierig. Also, es wäre jetzt noch einmal interessant, in welchem Alter diese Frauen (lacht) sind, die da dann Chefärzte sind. Ich glaube, dass weniger Frauen diesen Ehrgeiz haben, eine Chefarztposition zu erreichen, weil in dem Moment für Frauen sehr häufig Familie wichtiger ist als die Karriere und deswegen eben halt, wenn sie wählen sollten, dann_ Ich glaube nicht_ Ich glaube, es ist ganz, ganz schwer

möglich. Gibt einige Beispiele, aber es ist trotzdem ganz, ganz schwer möglich, eine gute Chefärztin zu sein und eine gute Mutter zu sein. Also, ich glaube, das, was_ Das sind so ein bisschen_ Das widerspricht sich so ein bisschen. Das kann ich halt auch nicht so richtig glauben_ die Frauen, die mir erzählen, dass das alles problemlos geht. Weil, dann geht es_ Es mag alles gehen, aber das ist dann nicht_ das ist dann nicht das, was eine in Anführungsstrichen ‚gute Mutter' für sich als gute Mutter auch beansprucht." (Ms. Persch)

According to Ms. Persch, it is almost impossible to combine family life with a career in medicine. In her opinion, it is in itself a contradiction; you can never be a good mother and a good chief physician. Ms. Doris also sees a problem when it comes to having children and a career. She states that women have to choose between either one of the two.

„Und ich glaube auch, dass es einfach viele Frauen gibt, gesellschaftlich betrachtet, die eher dann diese Entscheidung fällen müssen: Kind oder Karriere? Also, diese Entscheidung müssen nicht die Männer fällen, weil da immer noch klar ist, sie ergreifen den Beruf und vielleicht machen sie dann einmal zwei Monate Elternzeit, wenn es hochkommt, machen sie vielleicht einmal sechs Monate Elternzeit, aber im Grunde ist immer klar ab Abitur: Jetzt geht es ans Arbeiten. Und da ist nicht drin vorgesehen, dass man Auszeiten hat für Schwangerschaft, Geburt, Kindererziehung." (Ms. Doris)

As this excerpt highlights, it is not only that women do not want to have a chief position, but are also forced to choose between a family and a career. Men, on the other hand, do not have to make this decision since they are in many cases exempt from family caretaking. This puts women in a fairly disadvantaged position when it comes to career opportunities. Ms. Ebert explains how she experienced having an unequal position in relation to her male colleagues once she was having a family. From the moment she was pregnant, she was being pictured as a mother instead of a doctor, which immediately brought with it the feeling of competence deficiency.

„Also, ich sehe einfach nur, dass es total schwierig ist für Frauen. Also, es ist wirklich so, dass es scheinbar so ist, dass man sich wirklich entscheiden muss: Entweder Karriere oder Familie. Und solange da keine Familie ist, ist man_ ist es wirklich_ ist man gleichgestellt. Aber sobald man nur einen positiven Schwangerschaftstest hat oder sogar das Kind geboren ist, ist man eine ‚Mama', und da ist_ Sofort tritt da_ hat man auch wirklich so einen Verlust der Kompetenz. […] Also hier ist es immer noch so, dass man entweder die Karriere macht und die Ärztin ist, oder man hat Familie." (Ms. Ebert)

Indirectly, being a mother means being less eligible as a physician, forcing women to choose between a family and a career in medicine. But there is more to the matter. Having a family is not the only obstacle women face on the road to becoming a chief physician. Women have to work harder and prove themselves more than men in order to achieve the same status as men. According to Ms. Persch, this has partly to do with the fact that men are more self-conscious than women, resulting in the need for women to perform more in order to be perceived as good as their male colleagues. And even then, men are being chosen more often than women.

„Und ich glaube, da ist es so, dass […] es immer noch so ist, dass Frauen durchaus_ Wenn man jetzt vergleichen würde, würde ich immer noch sagen, dass Frauen mehr leisten müssen, um die gleiche_ um in die gleiche_ Also, auch an Fähigkeiten, an Sachen, die sie machen in der Klinik, dass sie da einfach mehr leisten müssen als ein Mann, um überhaupt so wahrgenommen zu werden wie ein Mann. Weil die Wahrnehmung eines Mannes eben durch dieses Selbstbewusste, durch dieses Auftreten einfach eine andere ist als die einer Frau. Und deswegen glaube ich immer noch: Es ist so, dass Frauen mehr leisten müssen, um genauso wahrgenommen zu werden wie ein Mann, und dass dann eben halt auch sehr häufig sich diejenigen für den Mann entscheiden." (Ms. Persch)

Thus, men are the standard and women have to work up to that in order to be observed at all. And even then, it is often the case that they are not perceived suitable enough for the job. According to Ms. Doris, this has to do with the fact that the traditional image of a chief physician still contains masculine characteristics. Therefore, it is easier to picture a man as a chief than a woman.

> „(überlegt) Ich glaube, dass es bisher_ Das knüpft so ein bisschen an das an, was wir vorhin hatten. Ich glaube, dass das im Moment noch als nicht kompetent genug gilt, also in Anführungszeichen ‚nicht kompetent genug', weil Frauen andere Eigenschaften mitbringen. Also, ich könnte mir vorstellen, dass wir in unserem_ aus unserer Historie heraus immer ein Bild davon haben, wie ein Chef sein muss. Und man versucht jetzt, glaube ich, Frauen in dann in dieses Bild reinzupressen, und ich glaube, dass das schwierig ist. Ich glaube, dass, wenn Frauen Chefs sind, sie anders Chef sind, deswegen aber nicht schlechter. Ich glaube nur, dass wir bisher kein Frauenbild etabliert haben von Chefsein, und dass das einfach im Moment uns Schwierigkeiten bereitet, dass wir uns Männer eher in dieser Chefposition vorstellen können als dass wir uns Frauen drin vorstellen können." (Ms. Doris)

Mr. Meister is not of opinion that women who want to advance to high level positions experience cultural or structural constraints. If women really have the desire to make a career, they can definitely achieve it, even with a family. He dedicates the fact that so few women are in chief positions to the lack of drive women have to take on such a job. According to him, women do not want to become chief physician and justify their choice by pointing to the incompatibility of such a task with family responsibilities.

> „Ich habe aber auch das Gefühl, dass Frauen ganz gern sich da auch so ein bisschen zurücklehnen und dann sagen, ja, ‚Das ist_ Die Bedingungen sind einfach schlecht', und jetzt_ aber trotz alledem nicht den Drive haben, das trotzdem zu machen, ja. Also, so. Sondern, ja, so, also, da habe ich_ habe ich ein bisschen Ärger gekriegt (lacht) […]

> Aber ich glaube es trotzdem, 'ne. Also, wenn jemand das innige Bedürfnis hat, irgendwo Karriere zu machen, egal eigentlich, in welchem Bereich, dann sind Kinder da jetzt nicht unbedingt hinderlich, ja." (Mr. Meister)

As Mr. Meister makes clear in his statement, he does not agree with the fact that women have fewer opportunities than men. I disagree with him concerning his argument. As is confirmed before by Ms. Ebert, women who are pregnant or have a family immediately have a different position in the organization. Furthermore, female qualities are not perceived as suitable for a chief physician, regardless if they are a mother or not.

The above excerpts on vertical segregation explicate how female characteristics do not fit the general image of a chief physician. Both Mr. Meister and Ms. Persch explain that male characteristics are favored in a chief physician. Men thus are the norm that women have to meet in order to be taken seriously. This is exactly what Acker (1990) means when she talks about the gendered substructure of an organization. Organizations are built on a structure where men are set as the norm. Masculine characteristics are necessary to become an ideal worker, "making it difficult for women's achievements to be recognized unless women work in masculine ways" (Lewis and Humbert, 2010, p. 242).

4.3.5 Organizational Change

Where the feminization of medicine has engendered some alterations in the department, in other areas the increase in female physicians has not affected the structures and practice of medicine at all.

According to the physicians in the Breast Center, the feminization process has caused for changes in the communication and ambiance in the team. Mr. Vogel explains how he has experienced this as an extremely positive effect of having

women in his team. Ms. Schmidt and Ms. Ebert also refer to women's communication skills, not only within the team, but also toward patients. But whereas feminization has affected communication style, it has not influenced the practice of medicine. According to Mr. Vogel, it is irrational to think that gender difference can influence the way medicine is practiced and also Ms. Schmidt states that the delivery of care depends more on guidelines than on gendered personal choices. Where gender is being neutralized by Ms. Schmidt and Mr. Vogel, Ms. Doris makes gender differences explicit in her account on the influence of feminization. She explains that women have a feminine way of doing medicine but that cultural and structural barriers do not allow for women to express this feminine side. But although Ms. Doris sees gender differences in practice style and therewith a potential for feminization, actual transformation fails to occur. Ms. Doris states that women masculinize their way of practicing medicine because they are being designated as too soft and as such not accepted in the current organizational culture.

Other aspects that have been brought to attention due to the increase of female physicians are family-friendly work structures and the possibility of part-time work. Ms. Ebert explains how these matters have become more important now that so many women have entered the work force. In the CAM section of the department, part-time work is a well-integrated phenomenon. None of the female physicians who work there have a full-time job. In the conventional medicine section, this is rather different. Although many of the interviewed physicians bring a feminization together with work-life balance issues and part-time jobs, the possibility of part-time work has not been realized yet. Organizational structures as well as a strong culture where extensive work hours are seen as normal, argue against this. The general opinion among the physicians is that long workdays are part of being a doctor. The women in the department underline this idea instead of transforming it. Ms. Persch, for example, repeats the system of long work hours by prioritizing her work over private life and by stating that being a doctor is a vocation, not a job. She has incorporated

the established culture and sees long work hours as an inevitable part of being a doctor, therewith reproducing the departments already established culture and structure. So where women have transformed the system in their way of communication, and in the demand for part-time work in the CAM section, they have engendered structural reproduction in the structure and practice of medicine in the conventional medicine section. Remarkably, the area where feminization has influenced medicine is where women's distinct behavior resonates with general gender stereotypes. For example, good communication is seen by the physicians as a feminine characteristic whereas analytical skills and practices are masculine. So women are allowed to outlive distinct gender traits when it fits the general opinion on work and gender behavior. In other words: structural transformation comes about when it is in line with the organizational culture and structure and structural reproduction takes place when the actions go against this either because women have internalized the existing organization culture or because they face structural constraint.

5 Discussion

5.1 The Three Departments as Gendered Organizations

In the next paragraphs, I will discuss the outcomes of my research and compare the Surgery department, the department of Internal and Integrative Medicine and the Breast Center with regard to the gendered composition of their organizational culture and structure and the influence of the feminization process on the organization and practice of medicine. I will then deliberate what this could mean for the future of medicine.

According to scholars like Moss Kanter (1970) and Acker (1990; 2008), organizations are not gender neutral institutions but highly gendered phenomena. Gender is both integral in, and constitutive of an organization's structure and culture. In his book on the dynamics of organization, Jones (2013) explains how organizational structure and culture are two distinct components of an organization but nevertheless emerge and evolve simultaneously. Therewith, the development of an organization's structure is inextricably related to the development of its culture and the other way around (Bate, Khan, Pye, 2000). Acker also refers to the co-constructive relationship between structure and culture. Both structural measurements and cultural values and images are essential in the composition of an organizations (gendered) substructure (Acker, 1990). She describes organizational culture as the construction of beliefs about gender differences that dictates and legitimizes how men and women should behave. Organizational structures, in turn, are based on the division of labor and job design (Acker, 1990). So although culture and structure are two distinct parts of an establishment, they are co-constructive in the building of an organization.

The interrelation of the two organizational components is clearly visible in the department of Surgery where a culture of long hours is reflected in the organizations structures that again foster a climate where overtime has become normalized. The department knows a strict hierarchy, long working hours and dedication to patients and the larger team. In this climate, it is not surprising that overtime has become a normalized aspect of being a surgeon. Although the formal rule enables physicians to leave the workplace when their shift ends, the informal rule expects them to stay until work is finished, patients are taken care of and every member of the team has completed his or her tasks. This distinction between formal and informal rules is an example of what Acker (1990) refers to as organizational logic; rules and expectations that come with the job. Although these rules and expectations seem to be gender neutral and to equally affect the organization's members, they are in fact not. They are based on the so called unencumbered worker who has no body and no

obligations outside the workplace (Acker, 1990). In the Surgery department, the image of the ideal doctor very much resembles this unencumbered worker. For women, it is more difficult to live up to this image than it is for men. Due to the division of labor, women are more likely to stay at home to take care of the family than their male colleagues. Because this picture is fixed in our minds, even women who do not have a family do not primarily fit the image of the ideal worker because they are not perceived as being as unencumbered as their male counterparts.

Research in the Surgery department with regard to part-time work possibilities shows how an organizational culture in which overtime has become normalized, dictates organizational structures that make part-time work difficult to accomplish and vice versa. Although the physicians in the department, including the chief, argue that part-time work should be possible, actual conversion has so far remained out. Furthermore, the part-time work models presented allow only a small reduction in hours as for it not to impede daily work structures. This creates an image a good doctor that strongly resembles Acker's abstract worker who is completely focused on the job and has no obligations outside the workplace. The surgeons in the department need to be abstract workers whose private lives should not impede their work. Although the rhetoric is that part-time work is possible, it is only achievable as long as it does not affect the daily work structures in the department. Mr. Peper even refers to the importance of "doing your work normally". Herewith, he implicitly argues that as a surgeon, you cannot do your work normally if you are not full-time available. Long hours have thus become a normalized part of the image of a good surgeon.

Although the long work hours in the department are seen as a natural and normal factor, they simultaneously are a point of frustration and dissatisfaction for the surgeons. They not only complain that the work hours are too long, but some of them even consider quitting the job on the long run because of the high time expenditure. But although the big time expenditure makes it difficult for the surgeons to have a

good work-life balance, they also see it as a sacrifice they have to make and an inevitable part of being a doctor. As Ms. Toman argues, being a physician is not like some other job where you can leave the work to be done for the next day. As a doctor, you need to be there for your patients and the rest of the team. Personal necessities are perceived as less important in such situations and have to be set back until work is finished. This image of what it takes to be a good doctor is conflicting with the wish for hourly cuts and part-time work, making it difficult to achieve the latter.

The department of Internal and Integrative Medicine bears some similarities with the Surgery department, but also differs in its culture and structure. In the Internal and Integrative Medicine department, hierarchies are not so firm and cooperation and good communication between the physicians are seen as important factors. The work hours are also more flexible than those in the Surgery department, leaving more room for the physicians' personal needs and wishes. As such, it seems that the department of Internal and Integrative Medicine gravely differs in its organizational culture and structure form the Surgery department. Instead of extremely long work hours, strong hierarchies and physicians that always need to be full-time available, the department of Internal and Integrative medicine knows a culture where democratic decision-making and emotional competence are more important. Furthermore, organizational structures leave room for the physicians' personal necessities. They can for example go home earlier to meet their yoga class and leave the rest of the work to be finished the next day, something that is rather uncommon in the other departments. However, when it comes to part-time work, the unit does not differ very much from the Surgery department. The reasons behind this, though, are slightly different. Whereas in the Surgery department, teamwork and patient care are given as a legitimization, in the department of Internal and Integrative Medicine, personal-based medicine is presented as the reason for the impossibility of part-time work. Furthermore, ward work is structured in such a manner that it cannot be taken care of with a part-time job.

The situation in the Breast Center bears a lot of similarities with the other two departments. In the conventional section of the center, work hours are long and overtime has become a normalized and accepted part of the job. The long work hours serve in the image building of a good doctor who is supposed to be unencumbered and sacrifices his or her personal life for the caretaking of patients. Several physicians in the department have more than once emphasized the fact that being a doctor is not a job, but a calling. As a result, they see it as more than normal that personal needs and wishes are set back in favor of work. The exception is the CAM section of the center, where all the physicians have part-time appointments, ranging from 10-20 hours a week. Part-time jobs are a lot easier to manage in this unit since the CAM physicians are not primarily responsible for the running of a ward but rather give additional care to patients. Although this gives them the possibility of a part-time job, it also means that they have an outsider position within in the larger department and are not always taken serious by their colleagues from the conventional medicine section. This example again underlines the image of the unencumbered, neutral worker that is set as the standard physicians have to live up to. Not meeting this norm means not being taken entirely serious as a doctor.

5.2 The Gender Component

As mentioned in the above paragraph, gender plays a significant role in the gendered substructure of organizations. The division of labor, organizing processes and organizational logic affect women differently than men. Because women are in many cases responsible for family caretaking, they are automatically perceived less favorable doctors, as in the case of Ms. Gras, Ms. Ebert and Ms. Doris who all experienced discrimination with regard to their part-time jobs. The unequal effects of structures on women also come forth in the department of Surgery where women are not allowed to execute operations during pregnancy which has in turn a negative

effect on the continuation of their training.

Another area where gender differences emerge is in what Acker (1990) calls organizational culture; shared norms and values that guide members' actions. These norms and values are fostered by symbols and images that define accepted and unaccepted gender behavior. Beliefs about gender differences in the departments dictate and legitimize how men and women should behave. In the case of the Surgery department, feminine stereotypical behavior is legitimate in ward work and patient care. But when it comes to surgical operations, rational and objective understandings of medicine guide the physicians' actions and gender differences are not permitted to play a role. Here, women are not allowed to express gender specific behavior but have to act just like their male colleagues. The same pattern is visible in the Breast Center where women are perceived as better communicators, but where gender differences are neutralized with regard to medical treatment and surgery. According to Mr. Vogel, it would be ridiculous to think that gender could influence medical decisions and treatments. In this case, you are a doctor, not a man or a woman.

In the department of Internal and Integrative Medicine, the image of a good doctor is strongly related to female characteristics. And although research on stereotypes has pointed out that the physicians in the department have clear stereotypic images of men and women, general statements on typical masculine behavior are always followed by an explanation that the male physicians in the Internal and Integrative department do not show this gender typical behavior.

Besides playing a major role in the structure and culture of the departments, gender distinctions and similarities also come forth in the outcome of the interviews. As the interviews have pointed out, there are no significant gender differences in the answers of the physicians with regard to work experience, the image of a good doctor, the feminization of medicine and ideas on stereotypes. In most cases, men and women have the same view on these matters. There is a slight difference in their work-life balance experiences and the wish for part-time work with a few more

women than men outing this desire. This is especially significant in the department of Internal and Integrative Medicine where almost all women have the wish to work part-time, either now or in the future whereas only one of the three men has this aspiration.

5.3 The Influence of Feminization

According to the literature on the feminization of medicine, the increase in female physicians will change the culture and structure of medical organizations and the way medicine is practiced. According to scholars like Kilminster et al. (2007), Elston (2009) and Heru (2005), an increase in female physicians will lead to an augmentation in the demand for part-time work, more family-friendly work structures in especially hospitals, and the advancement of women in high rank positions. Furthermore, the entering of women in the medical profession will engender a more patient-centered and humane care (Kilminster, Downes, Gough, Murdogh-Eaton, Roberts, 2007; Gray, Fabre, Brown, 2014; Riska, 2001; 2008; Heru, 2005). These expected effects are based on the idea that women have different qualities and characteristics from men and through the expression of these traits will engender structural and cultural change in the organization. But as this research has pointed out, these suggested alterations have not so straightforwardly taken place in the departments. This is partly due to the gendered substructures of the departments that contain specific structures, rules and cultures that prescribe how men and women should work and behave. In this paragraph, I will discuss how the feminization process has manifested itself in the departments and how it has distinctively affected the different organizational contexts.

The interviews with the physicians show that they in all three departments link an increase in female physicians with the exact same issues as is spoken about in the literature: part-time work, more family-friendly work structures and better

possibilities for women to combine a family and career. But when it comes to the actual conversion of these ideas and wishes into practical actions, change remains out. Part-time work opportunities are scarce in all three departments (with the exception of the CAM unit in the Breast Center) because organizational structures and culture do not allow for this to happen. In the Surgery department, for example, both men and women refer to an increase in part-time job opportunities due to the feminization process. Furthermore, the surgeons complain about the long workdays and talk about wanting to reduce their hours. But when I asked them about part-time job opportunities, they stated that they see it as an impossible accomplishment in the department's current system. Not only because of the lack of structures or the organization's culture that expects surgeons to be full-time available, but also because they themselves want to be there for the patients and the team.

In the department of Internal and Integrative Medicine, part-time work is not possible either. Although many of the physicians would like to reduce their hours, the head of the department explained them that a ward cannot be taken care of with a part-time job. But there are other factors that play a role as well. Ms. Gras, for example, used to work part-time. Although it was mainly due to structural problems that she stocked up again, she also states that she feels a better doctor now that she is working full-time again. She internalized the prevalent image of the good doctor as being unencumbered and full-time available and now works according to this standard. Thus instead of altering the structures in the department, she complies with the dominant system and as such reproduces the department's (gendered) substructure instead of changing it.

With regard to the advancement of women into leadership positions, the feminization process has not caused for changes in the departments either. All heads of department are male and, based on my interviews, it seems rather unlikely for women to take on these positions any time soon since none of them want to become a chief physician. The main reason that is given for the lack of women in management

positions is the incompatibility of a family with a career. According to the doctors, a chief physician inevitably has to spend many hours on the job. Ms. Bluhm, for example, explains that she expects her manager to always be present. Therefore, such a position is incompatible with the caretaking of a family. But there is more to the matter. Women do not fit the general image of a chief physician either, regardless of being a mother or not. The necessary qualities for being a good chief are still masculine designated, making it difficult for those women who wish to take on such a position to make it to the top.

When it comes to the practice of medicine, there are clear differences visible between the departments. The Surgery department and the Breast Center both separate ward work from surgical operations in relation to the influence of feminization on the practice of medicine. Where women are allowed to show gender distinct behavior in ward work, the existence of gender differences are not allowed with regard to surgical practices. So when it comes to gender typical work such as caretaking, women can express what the physicians refer to as 'feminine qualities', but in surgical operations, they have to adapt to 'gender neutral' standards and guidelines.

The physicians of the Internal and Integrative department seem to be more open toward the influence of the feminization process on the practice of medicine. Because their way of doing medicine already encompasses what they refer to as female qualities, they have a positive stand toward the influence of feminization on the practice of medicine. But the fact that this discipline has always been marked by femininity makes it difficult to establish the exact effects of the feminization process on the practice of medicine in the department.

Although the discussion so far might suggest that the feminization process has not affected the departments at all, this is certainly not the case. First of all, all departments experienced an increase in the number of female physicians working in the organization. Furthermore, the feminization of medicine has fostered a discussion

on the matter of family-friendly work structures and part-time work and actual changes have taken place in the CAM section of the Breast Center, where all physicians have part-time jobs. Although this has been the case since its grounding in 2006, Ms. Ebert explains that she never before has experienced this being a point of discussion in a hospital setting. Therewith, the debate on the feminization of medicine has also released a discussion in hospitals. The increase in female physicians has also caused transformation in ward work and the caretaking of patients. This is especially significant in the Surgery department where many physicians refer to the increasing quality of ward work since more women have entered the profession. Furthermore, women have caused changes in communication with patients and between the physicians themselves.

As the interviews lay bare, in those cases where structural transformation with regard to feminization has taken place, changes were consonant with the departments' dominant cultures and gender stereotypes. Research on stereotypes in the departments showed that the physicians generally designate women as more caring and communicative than men. It is exactly with regard to these characteristics that women are allowed to show gender distinct behavior. But in matters such as surgical operations, women have to adapt to a pre-determined (masculine) standard. In the department of Internal and Integrative medicine, the welcoming of female qualities also resonates with its general feminine culture. As such, gender segregation of jobs and tasks remain existent. What has changed, though, is that women are allowed in jobs like surgery where they were formerly excluded from. They can now part-take in areas that were previously masculine dominated but on the condition that they do not express gender specific behavior but adapt to the pre-existing way of working.

In those areas that were already feminine designated, like caretaking, communication and emotional handling, women are allowed to bring in a female specific gender component. These examples show the role the established

organizational culture and structure play in the determination of the influence of feminization on the departments.

5.4 Structure, Agency and Organizational Change

Where the feminization of medicine has engendered some alterations in the departments, in most cases the increase of female physicians has not affected the organization and practice of medicine at all. In order to analyze why and how a feminization influences medicine it is necessary to elaborate on how organizational change comes about. Organizational change is the outcome of the relative strength of structure and agency. According to Giddens (1979; 1984) structure and agency are an inseparable ontological unit; structures do not have an independent existence but exist in and through the actions of agents. For Giddens, agents always have the power to act otherwise with a change in action automatically leading to a change in structure. In the case of the feminization of medicine, this would mean that the female physicians who enter the profession always engender some sort of change. Archer (1982) disagrees with Giddens on this point, arguing for an ontological dualism instead of a duality because not all actions automatically transform structures. Agents do affect structures, but structures also exist apart and outside from agents. Structures sometimes exist prior to action and therewith form a context in which agents act. Serving as a context for actions, structures can enable but also constrain action. The degrees of freedom and constraint are dependent on the particular context and the position of agents (Archer 1982; 1996). Again, I would like to emphasize that structures in this case means the whole structural, cultural and organizational side of institutions. Actors are individuals who with their actions either cause the structural context to change, or to be reproduced. In the case of feminization, a high number of women are entering a certain structural context; an organization with a particular culture, structure and state of affairs that seems to be gender neutral, but that is not.

How women affect this organization depends on the interplay of their actions with their structural environment.

As I explained before, according to Giddens (1984), a change in action means a change in structure. But many doctors are confronted with structures they cannot change because they do not have the resources to do so. Archer reflects on this problem in her work, pointing toward the necessity to analyze the durability of constraint. She states that it is important to specify why some actions bring transformation and why some do not (Archer, 1982). Where Giddens (1984) sees every action as a transformative power, Archer argues for a specification of degrees of freedom and constraint in distinct structural context and for different social groups. Not every action automatically engenders change. The possibility to transform structures relates to the degrees of freedom, which in turn depends on the position of the actor and its structural environment (Archer, 1982).

In the department of Internal and Integrative Medicine, there seems to be a lot of room to alter matters. But as both Mr. Guhl and Mr. Fischer explain, degrees of freedom to influence affairs go hand in hand with the position of the physicians with the senior physicians having more freedom to alter things than the assistant physicians. Furthermore, although all physicians have the possibility to make their own decisions in a pre-given framework, the underlying structural context should not be contested. Ms. Gras, for example, experienced structural constraint in her wish for part-time work. When she began her job in the department, she worked 80% instead of full-time. But after realizing that due to the way ward work was structured and after having experienced discrimination in relation to her part-time job, she decided to stock up again. Ms. Gras experienced what Archer (1982) refers to as the durability of constraint. Ms. Gras entered an organization with a pre-given set of structures and although she tried to change matters with her actions, she was not able to engender transformation because structure appeared too constraining.

In the department of Surgery, a gap exists between the physicians' expectations of the feminization process and the conversion of these ideas and wishes. This is partly due to structural constraint. Many of the surgeons want change but they do not feel like they are in the position to bring transformation. According to them, change has to come from higher hand. They do not see themselves as actors who can alter the department's structures and ideas about work. So where an important factor for structural elaboration in the Surgery department lies in the constraining function of its structures, another contributing facet is the withdrawing of the physicians when it comes to actively trying to change the situation. Although the latter can be seen as a result of structural constraint, the issue also lies in the doctors' passive attitude toward transformation. In the cycle of structure and agency, agents always influence structures with their acts. But it depends on their strength if they result in transformation or reproduction. In the case of Surgery, the depersonalized account of feminization that the physicians have and their conviction that change is unachievable, makes that they (unintendedly) reproduce the department's structural context rather than changing it.

Just like the other departments, the Breast Center has experienced an increase in women doctors as well. But although this numerical feminization has caused for some changes to happen, in most cases the system as it was has been reproduced. Whereas Ms. Doris sees gender differences in practice style and therewith a potential for the feminization of medical care, she also explains how cultural and structural barriers do not allow for women to express this feminine side. In this case, the department´s dominant culture constraints women in their actions to change the deliverance of care. The same goes for the transformation of the department's organizational structures. Many of the interviewed physicians of the Breast Center bring a feminization together with family-friendly work structures and an increase in part-time jobs. But none of this has been realized yet because organizational structures as well as a strong culture of extensive work hours argue against this. The

general opinion among the physicians is that long workdays are part of being a doctor and can therefore not be changed. As such, the feminization process has not engendered transformation with regard to part-jobs but rather caused for a reproduction of the department´s already established culture and structure.

The examples given above on the interplay between structure and agency shows how little room the departments' pre-established gendered substructures leave for women who enter the profession to influence the organization and transform the structure and practice of medicine. Is also elaborates that not every action automatically leads to change but that it depends on the position and the resources of the physicians if transformation comes about.

5.5 The Future of Medicine

As this research has pointed out, all three investigated departments have experienced an increase in the number of female physicians over the last years. But has this engendered qualitative change as well? Although I cannot speak about the influence of the feminization of medicine in general, based on my studies in the hospital I can say that over the last years, more structural reproduction than transformation has taken place in the departments under investigation. As such, an increasing number of women entering medicine does not necessarily lead to qualitative changes in the profession. The reason for transformation to stay out is mainly due to the absence of strong differences in gendered behavior between male and female physicians and because of the gendered nature of the organizations. When female (and male) physicians enter a department, they face an organization with a certain (gendered) structure and culture that set ideas about work, the practice of medicine, skills of a good doctor and suiting gender behavior. If and how the increase of women changes these organizational components depends on the interplay of the physicians' agency with the structural context they operate in. In

those cases where women indeed have different demands from men and where they bring different traits and qualities to the profession, it depends on the relative strength of their agential forces if the system is reproduced or if structural transformation takes place. In the Surgery department, the Breast Center as well as in the department of Internal and Integrative Medicine, the increase in female physicians has in most cases resulted in structural reproduction to take place, either because gender differences in ideas about work where not present, because men and women had internalized prescribed gendered behavior, because women did not find themselves in the position to demand change, or because they acted out but faced structural constraint.

Because of the limited opportunities for change, women, consciously and unconsciously, comply with the system as it is or leave the hospital setting all together. It is hardly the case that they see opportunities to transform matters in their current situation. Ms. Siebel, for example, would like to have more free time and considers leaving the hospital to work in a practice where the opportunities for a good work-life balance are better. Ms. Bluhm is not certain if she wants to continue her work in the hospital either. Although it is manageable for her at the moment, it is not what she wants on a continuing basis.

> „[...] ich weiß noch_ also, weiß noch nicht so genau, wie lange ich noch in diesem_ in diesem dauernd sich drehenden Rädchen Krankenhaus so in der Form irgendwie bleiben möchte, so. Das ist jetzt im Moment okay und auch machbar und auch erträglich (lacht), aber auf die Dauer, haben wir ja eben schon gesagt_" (Ms. Bluhm)

Ms. Ott shares Ms. Bluhm's view. Now that she has finished her specialist training and has been appointed a position as senior physician, she reconsiders the continuation of this way of living.

> „Und ich bin jetzt 34 und ich glaube, ich bin jetzt an dem Punkt, wo ich auch nicht weiter Karriere machen will, 'ne. Also, ich habe jetzt meinen Facharzt, ich habe meine Doktorarbeit jetzt geschrieben, ich lerne jetzt operieren, 'ne. Und wenn das alles so ist, wie ich mir das vorstelle, dann ist auch einmal gut. Dann muss man auch evtl. gucken, ob man das wirklich so weiter haben möchte, diese Art von Leben." (Ms. Ott)

Because the physicians do not see the possibility for change within the departmental structure and culture, they either conform to the organization or decide to leave it all together, therewith indirectly reproducing instead of transforming the system that made them comply or leave in the first place. Contrary to this, the physicians in the CAM unit of the Breast Center seem very content with their current work situation. They do not mention considering to leave the hospital at all. But because of their special job and therewith their outsider position within the larger department, they are not really contesting the department's established structure either. As such, even though in some cases men and women have tried to influence the organizations they work in, grave structural transformation has so far remained out and structural reproduction has taken place in most areas of the three hospital departments.

6 Summary

In the last decade, Germany has seen a significant increase in the number of female physicians. Literature on the topic suggests that this so called "feminization of medicine" will engender changes in the profession's structure and the practice of medicine, resulting in an augmenting demand for part-time work, more women in high level positions and a stronger patient-centered and humane care. In order to analyze how feminization has influenced medicine, I conducted qualitative, semi-structured interviews with 21 male and female physicians holding diverse positions in a department of Surgery, a Breast Center and an Internal and Integrative Medicine department of a hospital in the Ruhr area in Germany. Using qualitative content analysis as an analytical framework, this thesis explains that an increase in the number of women doctors has taken place in the departments, but that this has not yet caused for major transformations to come about. Due to the gendered substructure of the departments, part-time work, with the exception of the complementary and alternative medicine unit in the Breast Center, is difficult to accomplish as is the compatibility of work and family life. Furthermore, clear guidelines on the provision of care leave little room for change in the practice of medicine. Most physicians do not see room to alter matters, with which organizational structures, cultures and practices in the distinct departments are in many facets reproduced instead of transformed. It is, however, not the case that the feminization process has not engendered any change at all. But modifications are only allowed when consonant with the dominant organizational culture, structures and prevalent gender stereotypes. As this thesis shows, the increase in female physicians has thus not automatically caused for qualitative changes to take place. It is rather the interplay between the agency of the physicians and organizational cultures and structures that determines how the increase of female physicians is affecting the organization and practice of care.

7 Zusammenfassung

In den letzten Jahren hat Deutschland einen deutlichen Zuwachs an weiblichen Ärzten erlebt. Gemäß der Literatur zur „Feminisierung der Medizin“ wird der Zuwachs an weiblichen Ärzten die Strukturen im Krankenhaus und die Praxis der Medizin verändern und zu mehr Teilzeitstellen, zu mehr Frauen in Führungspositionen und zu einer humaneren und stärker patientenzentrierten Versorgung führen. Um den Einfluss der Feminisierung auf die Medizin zu analysieren, führte ich qualitative, semi-strukturierte Interviews mit 21 Ärzten und Ärztinnen in verschiedenen Positionen in einer chirurgischen Abteilung, einem Brustzentrum sowie einer Abteilung für Innere und Integrative Medizin in einem Krankenhaus im Ruhrgebiet in Deutschland durch. Unter Verwendung von qualitativer Inhaltsanalyse erläutert diese Thesis, dass es einen deutlichen Anstieg des Ärztinnenanteils in den Abteilungen gegeben hat, aber dass dieser nicht zur großen Transformationen führte. Mit Ausnahme der Sektion der komplementären und alternativen Medizin des Brustzentrums, ist Teilzeitarbeit sowie die Vereinbarung von Arbeit und Familie wegen der *gendered* Substruktur der Abteilungen schwierig zu verwirklichen. Außerdem lassen klare Leitlinien in der medizinischen Versorgung die praktische Anwendung betreffend wenig Raum für Veränderungen. Dieses führt dazu, dass die Organisationsstrukturen, und -kultur und die medizinischen Anwendungsverfahren der Abteilungen in den meisten Fällen reproduziert statt geändert werden. Es ist jedoch nicht so, dass der Feminisierungsprozess gar keine Änderungen nach sich gezogen hat. Die Modifikationen sind allerdings nur erlaubt, wenn sie mit der dominanten Organisationskultur und den generellen Stereotypen harmonieren. Die gestiegene Zahl an Ärztinnen selbst hat also nicht direkt für qualitative Änderungen in die Abteilungen gesorgt, sondern vielmehr bestimmt das Zusammenspiel zwischen ärztlichem Agens und der Organisationsstruktur und –kultur den Effekt der Feminisierung auf die Organisation und die Praxis der Medizin.

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9 List of Abbreviations

CAM Complementary and Alternative Medicine

10 Appendixes

10.1 Questionnaire

- Introduktion von mir und meine Forschung.
- Aufklärung von Datennutzung und Datenschutz.
- Unterschreibung Einverständniserklärung.
- Recording

Topic	Fragen	Notizen
1.Introduktion	Erzählen Sie bitte etwas über Ihren bisherigen Werdegang in der Medizin.	
2.Spezialisierung	Aus welchen Gründen haben Sie sich für diese Spezialisierung entschieden? Aus welchen Gründen haben Sie sich für die Abteilung entschieden,	

	in der Sie momentan arbeiten? Was waren Ihre ursprünglichen Erwartungen von der Arbeit? Was ist Ihre jetzige Bewertung?	
3.Arbeitsfeld	Wie sieht Ihre typische Arbeitswoche aus? - Arbeitsstunden - Arbeitszeiten - Dienste - Feste Arbeitszeiten oder flexibler Einsatz Bitte erzählen Sie mir etwas über Ihre Arbeitsaufgaben.	
4.Privatleben	Bitte erzählen Sie mir etwas über Ihre Familiensituation? - Wer wohnt im Haushalt	

	- Kinder - Eltern/Schwiegereltern Wie werden die Kinder/Eltern/Schwiegereltern versorgt? - Kita - Partner Verteilung Wie werden die Aufgaben im Haushalt erledigt?	
5.Work-Life Balance	Wie kombinieren Sie Privatleben/Freizeit/Beruf? Wie zufrieden sind Sie mit Ihren jetzigen Arbeitszeitoptionen? Streben Sie etwas anderes an? Inwieweit haben Sie das Gefühl, dass Ihre Arbeitszeiteinteilung Ihre Arbeit positiv oder negativ beeinflusst? - Beispiel	

6.Arbeitsorganisation	Welche Veränderungen haben Sie in Ihrer Arbeitsstruktur wahrgenommen?
	- Organisationsstruktur
	- Arbeitsalltag
	- Arbeitsziele
	  o Allgemein
	  o Persönlich
	- Arbeitsverteilung
		Wenn der Person schon länger in der Abteilung arbeitet, fragen ob er oder sie Veränderungen in der Abteilung bemerkt haben. Frag sonst nach allgemeinen Veränderungen in der Medizin.
		
		Welche Strukturen sind präsent, haben diese sich geändert, wie reagieren Ärzten darauf?

7.Feminisierung	Inwieweit beobachten Sie eine Feminisierung in der Medizin? - Allgemein - Persönliche Erfahrung	*Falls das Antwort nein ist, fragen ob er oder sie schon mal von dem Term gehört hat, was er oder sie darunter versteht.*

	- In der jetzigen Abteilung - Beispiel Hat die Feminisierung Ihrer Meinung nach für Änderungen in die Medizin gesorgt? - Beispiel Was sind Ihre Einschätzungen für die Zukunft bezüglich des Feminisierungsprozesses? Welche Position nehmen Frauen in Ihre Organisation ein? Welche Position nehmen Männer in Ihre Organisation ein?	
8.Arztberuf	Welche Kompetenzen und Eigenschaften sind wichtig für den Arztberuf? Erst als offene Frage, dann Attributen abfragen eher wichtig oder unwichtig: *fürsorglich, kommunikativ, zielorientiert, bestimmend, ambitiös, effizient, analytisch, mitfühlend, aufgeschlossen, selbstbewusst.* - Sehen Sie Unterschieden zwischen Ärzten und Ärztinnen? D.h. erwarten Sie von Männern andere Kompetenzen als von	

	Frauen? Erfahren Sie das Frauen anders arbeiten als Männer? Was macht ein guter Chefarzt? Erst als offene Frage. Dann Attributen abfragen; die 5 wichtigste aus der Liste: *fürsorglich, kommunikativ, zielorientiert, bestimmend, ambitiös, effizient, analytisch, mitfühlend, aufgeschlossen, selbstbewusst.* Würden Sie die folgenden Attributen als eher Männlich oder eher Weiblich sehen: *fürsorglich, kommunikativ, zielorientiert, bestimmend, ambitiös, effizient, analytisch, mitfühlend, aufgeschlossen, selbstbewusst.* Obwohl 60% der Ärzte weiblich sind, sind nur 8% der Chefärzte weiblich. Woran liegt das Ihrer Meinung nach? - Wird Frauen der Zugang verwehrt? - Oder wollen Frauen nicht? Wie sieht das in Ihre Abteilung aus? Welche Erfahrungen haben Sie diesbezüglich gemacht?	

9. Arbeitsvorstellung	Was sind Ihre Wünsche und Vorstellungen von der Arbeit? Wie setzen Sie Ihre Wünsche und Vorstellungen von der Arbeit um? Was müsste passieren, damit Sie ihre Vorstellungen von der Arbeit durchführen könnten?	
10. Abschluss	Wie sehen sie ihre Zukunft? - Familie oder Arbeit zentral - Oberarzt/Chefarztstelle - Vollzeit/Teilzeit Herzlichen Dank für Ihre Mitarbeit. Haben Sie noch weitere Fragen oder Anmerkungen?	

10.2 Research on Stereotypes

The numbers in the tables refer to the amount of physicians that designated the particular characteristic as masculine, feminine or equal.

Gender Stereotypes in the Surgery Department

	Masculine	Feminine	Equal
Caring		7	
Communicative		5	2
Goal-oriented	4	1	2
Assertive	4		3
Ambitious	1	2	4
Efficient	3	3	1
Analytical	4		3
Compassionate		7	
Open-minded		4	3
Self-conscious	3	1	3

Gender Stereotypes in the Internal and Integrative Department

	Masculine	Feminine	Equal
Caring		6	1
Communicative		7	
Goal-oriented	6		1
Assertive	6		1
Ambitious	4		3
Efficient	2		5
Analytical	4		3
Compassionate		6	1
Open-minded		3	4
Self-conscious	6		1

Gender Stereotypes in the Breast Center

	Masculine	Feminine	Equal
Caring		7	
Communicative		6	1
Goal-oriented	6		1
Assertive	4		3
Ambitious	3		4
Efficient	1	3	3
Analytical	5		2
Compassionate		6	1
Open-minded		1	6
Self-conscious	6		1

10.3 Sample

Department of Surgery

Name	Position	Age
Mr. Schneider	Chief Physician	50-60
Mr. Peper	Senior Physician	40-50
Ms. Ott	Senior Physician	40-50
Ms. Bluhm	Assistant Specialist Physician	30-40
Ms. Toman	Assistant Specialist Physician	30-40
Ms. Mohr	Assistant Physician	30-40
Ms. Adler	Assistant Physician	20-30

Department of Integrative and Internal Medicine

Name	Position	Age
Mr. Guhl	Senior Physician	40-50
Mr. Fischer	Senior Physician	30-40
Ms. Gras	Assistant Specialist Physician	30-40
Ms. Ludwig	Assistant Specialist Physician	40-50
Ms. Siebel	Assistant Physician	20-30
Ms. Hartmann	Assistant Physician	30-40
Mr. Hein	Assistant Physician	30-40

Breast Center

Name	Position	Age
Mr. Amon	Chief Physician	40-50
Mr. Vogel	Senior Physician	60-70
Ms. Persch	Senior Physician	30-40
Mr. Meister	Assistant Specialist Physician	30-40
Ms. Schmidt	Senior Physician	40-50
Ms. Doris	Assistant Specialist Physician	30-40
Ms. Ebert	Assistant Specialist Physician	30-40

10.4 Code List

Code System [1020]

- Decision Medicine [0]
  - Flexibility [1]
- Decision Specialization [7]
  - In the family [2]
  - No clear decision/goal [6]
  - Manual Job [4]
  - Secure Job [2]
  - Money [0]
  - Help patients [1]
  - Direct visible effects [7]
  - Unsatisfied with conventional medicine [7]
  - Healing/Cure [3]
- Expectations of Medical Profession [4]
  - Know upfront what profession is like [2]
  - Discrepance between Expectations and Reality [3]
  - Fears excessive workload and high demands [1]
- Current job valuation [2]
  - Makes sense [1]
  - Profession is hobby [3]
  - Lot of paperwork [2]
  - High workload [3]
  - Time consuming [4]
  - Unsatisfied [2]
    - Unsatisified but stays [1]
    - Wish for more self-determination [2]
    - More time off [4]
  - Satisfied [12]
  - Stress [4]
    - Coordination of both OP and Ward [1]
- Work-Life Balance [39]
  - Clear balance [1]
  - Wife gave up work [1]
  - Work determines private [11]
  - Private determines work [0]
  - Work central place [8]
  - I like to do my work [8]
  - Wenig privat/freizeit [15]
  - Either Career or Family [8]
  - Difficulties to balance [6]
  - Incompatability Family and Career [7]
- Organisational Structures [36]
  - Organic [2]
  - Have not changed [2]
  - Well organized [2]
  - You stay until work is finished [4]
  - Predetermined guidelines [4]
  - Limitate work-life balance [1]
  - Lack of Structure [1]
  - Shortage of personal [6]
  - Work intensification [3]
  - Money and laws more important than patients [5]
  - Work with Patients [3]
  - Specialist training surgery [4]
  - Not enough time for patients [8]
  - Unchangeable [12]
  - Working hours [34]
    - OK for limited time [1]
    - Negative impact [2]
    - Satisfied [2]

- Unsatisfied [14]
- Should be content [1]
- Part-time in Hospital impossible [10]
- Overtime [22]
  - Used to it [4]
  - No payment or compensation [3]
  - Comes with the job [5]

Time Management [3]

Organisational Culture [10]

- Room for individual [2]
- Understandfull Team [1]
- Willing to invest time [2]
- Self-evident [3]
- Part-time undervalued [1]
- Women in Surgery more dominant than other Professions [1]
- Only mothers accepted as part-time employees [3]
- Our department differs from other typical departments [6]
  - OP is main goal [1]
  - In surgery you need elbows [2]
  - Not a typical 'hard' surgery department [3]
  - CAM different kind of medicine [5]
    - Employee criteria [1]
    - Men more soft skills [1]
    - More women [1]
    - Need of academic research [1]
    - You need emotional reflection [2]
    - Men more patient centered [2]
- Change in Status Profession [2]
- Part-time mother [1]
- Abstract Worker [9]
- Abstract Idea of Profession [8]
- Team negativ [4]
- Team Positiv [4]
- Prasenzdogma [11]

Feminization [11]

- Status goes down [1]
- No strong appearance [1]
- Change in Medicine through fem? [5]
  - Women shaped like men [1]
  - Rational approach is necessary [1]
  - No change because men still on high ranks [1]
- Feminization in Numbers [18]
  - Maennerquote [1]
- Feminization of Medical Practice [17]
  - Should not affect [2]
  - Negative Effects on Patient Care [1]
  - More empathy [9]
  - Better Care [0]
  - No effects [9]
    - Not enough time [1]
  - Carefull OP [2]
  - Ward Work [3]
- Feminization on an Organisation Level [18]
  - Different qualities become important [3]
  - Challenge for Medical World [3]
  - Part-time work more relevant [9]
  - Cat fight [4]
  - Better Communication [9]
- Women can make career in Medicine [3]

Reasons against becoming female chief [6]

- Too much beaurocracy [1]
- No ambition [4]
- Preference to have family [5]

Reasons against becoming chief [0]
- Want to stay in clinic [1]
- Unorganized [1]

Hierarchies [1]
- Not so strong [1]
- Strict Hierarchies [13]
- Chief decides guidelines [10]
  - Chef entscheidet [6]

Scope for action and decisionmaking [11]
- Realizability of wishes and ideas [8]
  - Chef decides what he wants [3]
- Not taking action [5]
  - It has to come from higher ranks [4]
  - It is what it is [1]
- Autonomy assistent physicians [8]

Vertical Segregation [36]
- Women do not have the right qualities [2]
- Women need to be dominant [5]
- Career break unfortunate [3]
- Matter of time [5]
- Women haven't found their place yet [4]
- Women do not want career [15]
  - More focussed on family [1]
- impossible to combine career and family [23]
- Failing networks [0]

Horizontal Segregation [7]
- Division between OP and Ward [1]
- Gender typical specialization [4]

Image of Good Doctor [6]
- Empathy [1]
- Structured [1]
- Need a certain distance [3]
- Technical Skills [6]
- Concern with patients [12]
- Status Chirurgie [1]

What makes a good Chief Physician? [0]
- Visionary [1]
- Compassion [1]
- respond to employees [6]
- Good knowledge [2]
- Good overview [6]
- Dominance necessary [2]
- Feedback [3]
- Motiviert Mitarbeiter [7]

Gender Stereotypes [21]
- Men more ambitious [2]
- Men more distanced [4]
- Men take less care about patients [3]
- Men more effizient [1]
- Men think quicker and simpler [3]
- Men more analytic [2]
- Women are more precise [1]
- Women are more sensitive [15]
- Women at home, men at work [1]
- Natural thing [2]
- Gender Difference [12]
  - Gender Differences [2]

- Gender Typical Work [4]
- Descriptive Norms [5]
- Injunctive Norms [1]
- Women good carers [1]
- Gender Expectations [3]
- Does not expect differences [2]
- Gender Inequality [15]
- Men preferred over women [4]
- Women have to work harder to get a position [3]
- Gender Naturalization [13]

Future Plans [11]
- Good Work Life Balance [3]
- Full time [3]
- Husband stays at home [0]
- More time off [1]
- Family central place [7]
- Work central place [4]
- Work in a Practice [2]
- Part-Time Work [7]

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12 Tabular Curriculum Vitae

Because of data protection a curriculum vitae is not included in the online version of this dissertation.