Contradictions concerning care: Female surgeons’ accounts of the repression and resurfacing of care in their profession
Contradictions concerning care: Female surgeons’ accounts of the repression and resurfacing of care in their profession

ABSTRACT

Surgery is a high-status, distinctly embodied, profession, dominated by men and saturated with masculine ideals of individual heroism, manual skill and detachment. In this study, we focus on exploring how surgery both represses, but also requires, caring work, creating gendered contradictions for the women that enter its ranks. Based on interviews with eighteen female surgeons from Australia and New Zealand, we apply a ‘rationality of caring work’ lens to explore how they experienced these contradictions through training, socialization and in everyday interactions. Our findings show inter-related mechanisms whereby female surgeons are required to become more independent and self-reliant than comparable men, but also make up for the systemic lack of care shown to junior staff and students. In particular, their pregnancy and motherhood challenge the ideal of the detached, independent, heroic agent. We conclude by discussing how a ‘rationality of caring’ lens could help unpack the gendered contradictions women experience in other elite professions.

Keywords:

Gender, care, professions, medicine, surgery, accounts
INTRODUCTION

Widely regarded as an elite among medical specialities, surgery is a profession numerically dominated by men and historically ‘sex-typed’ as male, i.e., carrying masculine associations (Crompton, 1987; Milkman, 1983). To those outside, surgeons are generally regarded as heroic, superior individuals whose decisive action, clinical detachment, authority and manual skill saves the lives of others (see Hinze, 1999). Like other professions, its status was secured through inter-related processes of excluding women from entry while also depending on their support and care work, both inside and outside the paid workforce (see Davies, 1996). While women did eventually secure entry through the institutionalization of ‘gender-neutral’ criteria of individual merit, and access to education (Witz, 1990), this does not mean they have been fully integrated (Wallace, 2014). In fact, surgery is one area of medicine that has been particularly resistant to change, both in terms of increasing the numbers of women and its persistent ‘sex-typing’ as masculine.

It is not just that surgeons are mostly men, while those that support them – nurses, administrative and clerical staff – are predominantly women, but that the masculine surgical ideal is predicated on suppressing the feminine, including care and caring work (see Davies, 1995, 1996). Women are included in medical work, but in a way that maintains the gendered assumptions upon which surgery is based. A female surgeon thus represents a cultural contradiction – the “wrong body in the wrong place” (Cassell 1996, p. 44) whose presence threatens to contaminate and complicate the established gendered order of work.

In this paper, we build on extant literature on women in surgery by focusing on one particular aspect of its gendered ideology: how the ideal of masculine professional independence, competence and individual agency is only able to be sustained by the repression of caring, its specific attachments, obligations and unpredictable demands.
We present findings from a qualitative study of Australian and New Zealander female surgeons undertaken in the six months prior to an inquiry into bullying and sexual harassment launched by the Royal Australasian College of Surgeons in 2015. In applying a ‘rationality of caring work’ lens (Waerness, 1984; Davies, 1995) to analyse our interviews with eighteen female surgeons, we focus on the gendered contradictions between care and competence they experienced during their professional enculturation and informal interactions at work (Acker, 2006; Wright, 2016). We identified three main contradictions: how they were required to demonstrate a ‘toughness’ and independence that not only lived up to the surgical ideal but surpassed it; the expectation they would compensate for a lack of care within surgery to patients, other staff and students at the same time as this work was devalued and invisible; and the seeming irreconcilability of motherhood and caregiving with a surgical career.

Our research contributes to knowledge about women in surgery by furthering understanding of the gendered contradictions between care and competence and the way these are connected by an underlying logic. In particular, we show how care is repressed, but also resurfaces, all of which are heightened and made more visible when women occupy the surgical role. Moreover, we further develop Waerness’ (1984) and Davies’ (1995) idea of a ‘rationality of caring work’ and show its potential for studying not only those roles with a dominant ‘care-orientation’ but professions antithetical to care. In particular, it can help to further explore why and how women’s presence in these professions is made difficult. While surgery represents an extreme case of the repression of care and its gendered contradictions, we argue that the processes we identify could also be used to study women’s experiences of other elite masculine professions.

We begin by locating our study within the broader literature on the gendered nature of the professions and how it is built around the repression of, but also need for, care. We then explain how surgery exemplifies this dynamic, reviewing existing literature on women in this elite occupation to justify our focus on the gendered contradictions between developing professional
competence and legitimacy, and responding to the devaluing and lack of care. This is followed by an overview of the surgical training and qualification system in Australia and New Zealand and how we approached our research. After presenting our findings, we conclude by discussing the contributions our study makes to existing knowledge about women in surgery and the potential it has to be applied to other elite professions.

GENDER AND PROFESSIONS

Surgery occupies the pinnacle within a hierarchy of one of the elite professions, medicine, that along with law and the Church were historically ‘sex-typed’ as male (Crompton, 1987; Milkman, 1983), i.e. dominated by men and imbued with masculine associations. As a result, feminist scholars have argued that the very meaning of ‘profession’ is gendered (e.g. Healy, Broadbent & Strachan, 2018, p. 3), the outcome of particular historical struggles and circumstances involving the exclusion of women, and devaluing work culturally associated with the ‘feminine’ including care and caring work (Crompton, 1987; Davies, 1996; Witz, 1990, 1992). However, while this masculine, professional ideal repressed ‘feminine’ care, it also depended on it for its reproduction and it is this central gendered contradiction we explore in women’s accounts of their experiences as surgeons.

Historically, the gendered nature of ‘profession’ was accomplished through several interrelated processes. High-status professions claimed ownership of a distinct body of knowledge and established regulatory mechanisms to control entrance by systems of education, licensing and supervised training and practice. These were used to exclude women and resist moves to grant related or comparable female-typed occupations (such as teaching and nursing) as having comparable ‘professional’ status. This drew upon, and reinforced, a gendered binary between technical skill, rationality and individual detachment from others (all of which carried masculine connotations) and social skills, emotionality and relationship or connection with
others (associated with women and the feminine). Occupations seen as requiring the former have been more highly valued, compared to the latter (Crompton, 1987; Davies, 1996). Indeed, it is their relative value that was, and continues to be, central to the lower economic and social status of jobs ‘sex-typed’ (Milkman, 1983, p. 193) as feminine and numerically dominated by women. In other words, ‘masculine’ professional privilege was only secured because of the relative devaluing of jobs deemed ‘feminine’ and the historical circumstances under which this emerges and becomes ‘crystallized’ in a profession are important in understanding the intransigence of its ‘sex-typing’.

In addition, the elite status of male professions was achieved by including women in less visible and valued ‘support roles’ without which the detached, autonomous, professional ideal could not be maintained (Davies, 1996). Davies (1996) illustrates this through the gendered division of labour in hospitals where the doctor’s proper ‘professional’ manner involves a ‘fleeting encounter’ (p. 670) with the patient, only possible by much administrative, preparatory and care work by clerical and nursing staff. The mythology of doctors’ ‘professional autonomy’, its agentic character and distance from recipients depends upon the work of others, often women, who have more sustained, embodied contact and personal relationships with patients or clients. Profession, therefore, is predicated on a denial of the feminine, even in an area where pain and vulnerability are at their most obvious and overt (Davies, 1995 p. 26). But as Davies argues “[t]his work is rarely acknowledged or well conceptualised; from the point of view of the gendered professional ideal it is regarded as trivial or as ‘support’” (p. 671). While nursing may be a paradigm case of feminized caring work and its devaluation, such analysis has broader relevance for understanding why caring and ‘emotion work’ is difficult to reconcile with the ideology of ‘professional competence’. In particular, work involving care for others exposes the ‘gendered binary’ upon which the masculine ideology of the detached, independent professional depends.
Making care work more visible requires recognition of the variety of forms it takes and the connections between them, both inside and outside the workplace, as well as how it is repressed in the public world but also vital to its reproduction. Davies (1995: 18-19) defines caring work as

attending, physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other. This can mean just ‘being there for’ someone, not necessarily listening, not necessarily even being physically present, but being known to be available, checking the situation out from time to time and being ready to respond if asked. (pp. 18-19)

Here Davies draws explicitly on Waerness’ (1984) idea of a ‘rationality of care’. Rather than being antithetical to rationality, as suggested by the fundamental dichotomies in Western thought (reason/emotion, public/private, work/home), Waerness (1984) argued caring possessed its own kind of rationality, that encompassed emotion and instinct, but also learning of skills, knowledge and ‘rules for proceeding’ (p. 194). In its sustained, personal connection with another, it differed from the detachment of science, but was no less ‘rational’ as a result. Further, Waerness distinguished qualitatively different types of caring: between ‘healthy adults’ (which would be symmetrical and reciprocated) from caring for dependents (i.e. ‘those who cannot take care of themselves’ (p. 188 such as the sick, elderly and young children) and caring for superiors. The secretary anticipating the physical and emotional needs of her manager, and organizing their life outside of work (as discussed by Pringle, 1989) would be an example of caring for a superior more akin to ‘personal services’ (Waerness, 1984); the mother who ‘chooses’ to transition into a part-time role to care for her family and allow her male partner to dedicate himself to career combines caring for dependents (in the case of younger children) with ‘personal service’ provided to another adult. Of course, major responsibility for household care also falls to women working full-time, an inequitable gendered distribution
examined at length by Hochschild (2012) who labelled it women’s ‘second shift’. Like Waerness, Hochschild stresses the importance of such caring work, which should attract greater visibility and value, given it is essential to social reproduction. Yet the time pressures, competitiveness and inflexibility of contemporary careers make this difficult to achieve. Both in their role within the family and in paid work, Waerness (1984) suggests women experience ‘dual-lives’ (p. 202) where the core tension between independence and instrumentality on the one hand, and dependence and expressiveness on the other, is played out. Such tensions may be heightened as women enter professions where competence requires learning adherence to masculine ideals of independence, impartiality and detachment.

Admittedly, professions have also undergone change as greater numbers of women enter their ranks. In the UK, as in Canada, the U.S. and Australia, more women are enrolling in medical education and the numbers of women in general practice have increased leading some to argue medicine has become more feminized at least in a numerical sense (Tsouroufli, 2015; Walsh, 2013). At the same time, such increases have been controversial. Women who opt for part-time or non-hospital positions with more regular hours risk being labelled as not ‘proper doctors’ (Allen, 2005, p. 569 cited in Walsh, 2013; Wallace, 2014; Tsouroufli et al., 2011; Özbilgin et al. 2011). Along with greater flexibility in training and work patterns associated with the introduction of the working time directive in the UK, the greater presence of women in medicine has been constructed as contributing to a decline in medical professionalism, excellence and quality of care with nostalgia for ‘all-hours’ availability (Bolton, Muzio & Boyd-Quinn, 2011; Özbilgin et al., 2011; Tsouroufli et al., 2011; Tsouroufli, 2015; Wallace, 2014; Walsh, 2013).
However, one medical speciality that has remained consistently male-dominated is surgery. Not coincidentally, its status at the top of the medical hierarchy is unchallenged and it exemplifies the detached, agentic, masculine professional ideal with its simultaneous repression of, and dependence on, care work. In many Western countries, including Australia, women in surgery remain in a numerical minority that has not substantially increased over time (Cochran et al., 2013a, 2013b; Tsouroufli et al., 2011; Tsouroufli, 2018a, 2018b; Wallace, 2014; Walsh, 2013; Webster et al., 2016). Previous quantitative research of female surgeons in the US has shown they perceive being treated differently (i.e. less favourably) than comparable men (Lebares et al., 2018; Seeman et al., 2016; Salles et al., 2018) and report feeling excluded and isolated, particularly in early career (Cochran et al., 2013a, 2013b). There is also evidence they are evaluated less positively than men during surgical residency (Gerull et al., 2019). Such findings provide support for Crompton’s (1987) earlier argument that while women may attain admission into a profession and achieve formal equality in terms of pay rates and working conditions, the organizational context in which they practice that profession, such as particular hospitals, can generate other forms of gender exclusion that are ‘extremely difficult to research and quantify’ (p. 423). It is necessary then not only to analyse how gender is ‘actively maintained and reproduced’ (p. 424) at the level of the profession but also individuals’ location and experiences within that occupational structure.

Qualitative studies of women in surgery have provided further understanding of how gender makes a difference. For example, an earlier ethnographic study by Cassell (1996, 1998) detailed how female surgeons were routinely marginalized, treated less favourably during surgical training and subject to higher performance standards. These findings resonate with a later study by Webster and colleagues (2016) whose interviewees described situations in hospitals where they received less support from nurses and administrative staff and had to exert extra effort to build cooperative relationships with them. They could not ‘get away with’ acting
in the same way that male surgeons would, behaviour that carried masculine associations but also signified the decisiveness and authority necessary to be seen as competent and legitimate. This meant that female surgeons had to engage in more self-monitoring and self-management in interactions with others, including ensuring their appearance and manner signalled appropriate female ‘respectability’ while not drawing attention to their femininity or sexuality (e.g. see also Tsouroufli, 2018a). A pregnant surgeon was considered ‘unspeakably wrong’ because it offended the ideal of a surgeon as invulnerable and independent (Cassell 1998, p. 189). Motherhood and caregiving seem particularly difficult to reconcile with a surgical career (Cassell 1998; Cochran, et al. 2013a, 2013b; Seeman, et al., 2016; Wallace, 2014) as both are ‘greedy institutions’ (Coser, 1974 cited in Cassell 1998 and Tsouroufli, 2018b) the gendered norms of which demand undivided attention and personal presence. And yet, they are also expected to undertake more of the less visible emotional labour, that is to say, pastoral care, support and mentoring of medical students and surgical trainees which Tsouroufli (2018a) refers to as affective feminine pedagogy.

Research into the experience of female surgeons has shown then, that they engage in complex navigation of contradictory gendered dynamics, both upholding the myth of gender-neutral merit, distancing from the ‘feminine’ and denying the relevance of gender at the same time as recounting how their gender has impacted negatively on their work life and careers (e.g. Webster, et al. 2016). This resonates with research on women in other STEMM fields, for example, several studies of women in science and engineering (Faulkner, 2009; Haas, Koeszegi and Zedlacher, 2016; Hatmaker, 2013; Rhoton, 2011; Rodriguez, 2013) have shown how they are called upon to “justify their presence” (p. 400) because their occupation is considered to be ‘gender in/authentic’ (Faulkner, 2009), due to the persistent gendered binary between technical and social skills and the masculine-typing of the occupation. As a consequence, regardless of their qualifications, seniority and experience, in interactions with others, their presence may be
contested and ‘misrecognised’ (e.g. mistaken for being a secretary, see Faulkner, 2009). In various ways, their gender may be foregrounded in an attempt to call into question their professional competence, for example, by sexualizing them, doubting their technical abilities, ignoring their contributions (Rodriguez, 2013), or expecting them to nurture others in the workplace, particularly if they are already mothers (Faulkner, 2009).

However, while there are similarities between STEMM fields, surgery has specific gendered cultural associations generated from its “uniquely physical, distinctively embodied” (Cassell, 1996, p. 41) character. Surgical practice is unequivocally a “hands-on” profession (Hinze, 1999, p. 226; see also Cassell 1998, p. 32) involving manual skills and physical contact. The more invasive the procedure, the more status accrues to the surgeons performing it. Cassell (1996) has argued longstanding dualisms between male and female, mind and body, culture and nature, reason and emotion underpin the (masculinized) ideal of surgeon acting upon and controlling a passive, risky, unstable and vulnerable (femininized) body. Female surgeons then, transgress this established gendered order and represent a cultural contradiction: the “wrong body in the wrong place” (pp. 43-44), and risk appearing ‘inauthentic’ at the same time as they are highly visible because of their rarity (cf. Faulkner, 2009).

This underlying contradiction may be manifested in various ways, but we argue it is perhaps most acute in relation to the simultaneous repression of, and need for, care and caring work. While previous research has included examples of how this plays out in female surgeons’ interactions with others, (e.g. Webster, et al. 2016; Tsourfouli, 2018a) it has not been the primary conceptual focus. In our study, we build on this work by explicitly applying a ‘rationality of caring’ lens (Waerness, 1984) to better understand how female surgeons account for their experiences. To date, this lens has mostly been applied in research about ‘caring’ occupations dominated by women such as childcare, eldercare, domestic service, welfare and social work, and nursing, as well as unpaid caregiving (e.g. Abel 1989; Brennan, Cass et al.,
2012; Davies, 1995; Elwér, Áléx and Hammerstrom 2010; Graham 1991; Henriksson, Wrede and Burau 2006; Vabø 2012). This is not surprising given Waerness developed this theory in the context of Norwegian government moves to replace publicly funded welfare services by informal caring, mostly provided by women, at the same time as women were trying to participate in paid employment, often in lower-status and lower-paid jobs that were also related to caregiving. Like Davies (1995, 1996) scholarship on nursing, Waerness’ (1984) goal was to make this ‘caring work’ more visible and show how it involved emotion and personal connection as well as mastery of a learned body of skills and knowledge. While we are following both Waerness (1984) and Davies (1995, 1996) in our attempt to make ‘caring work’ more visible, we do so in relation to an elite profession that represents an extreme case of the masculine, detached, professional ideal which both represses and requires care to sustain it. Our research not only extends current knowledge about women in surgery, but also allows us to explore how they experience the contradictions between care and competence that underpin elite, male-dominated professions more generally.

METHODOLOGY

We understand professions to be gendered institutions in the sense that relative values attributed to masculinity and femininity are central to their meanings. Moreover, if “being a professional and being a woman are active processes”, (Bolton & Muzio, 2007, p. 52), then studying people’s understandings of their everyday interactions can illuminate our understanding of how gendered norms and institutions are variously done, undone, resisted and accommodated (Acker, 2006; Hatmaker, 2013; Neal & Murji, 2015; Wright, 2016). In Ridgeway’s (2009, p. 4) words:
“…to fully understand how gender is done one ought to pay attention not only to structuring ideologies and discourses, but also ‘daily interactive processes… as described by actors themselves.”

This suggests we need to go beyond simple reporting or recording of practices and examine accounts of incidents, exchanges and daily work. Like Wright (2016), Faulkner (2009) and Webster et al. (2016), we aim to explore how female professionals in a specific male-dominated STEMM field explain the gendered contradictions they encounter. In particular, reflecting our interest in a ‘rationality of care’, the research question, we sought to explore was: how do female surgeons account for their experiences of care and caring work over the course of their training, socialization and careers?

**Context, data collection and analysis**

In order to contextualize the accounts of our interviewees, some background to the surgical training system is warranted. In comparison to the UK (see Bolton et al., 2011), in Australia and New Zealand the apprentice-style process is still in place, with surgeons in training guided by master surgeons who assess their competence (RACS, 2018a). Those admitted to the Royal Australasian College of Surgeons (RACS) have passed the Fellowship exam, and undergone several years of clinical placements through the accredited RACS trainee program. Prior to being accepted into the program, individuals must have completed a medical degree at an Australian or New Zealand university. Each of the RACS’ speciality groupings - cardiothoracic, general (including e.g. trauma, oncology, breast, colorectal, gastroenterological), neurosurgery, orthopaedic, otolaryngology (eye, ear, nose and throat), paediatric, plastic and reconstructive, urology and vascular – select a number of candidates annually into their programs which are designed to equip trainees with the skills to become fully practising Fellows in their respective specialty areas. RACS provides an overarching
competency framework to direct and guide assessment for trainees (see RACS, 2018a) but it is still senior surgeons who assess trainee progress.

The population of qualified female RACS surgeons is small and less progress has been made at increasing the proportion of women in surgery than in medicine more generally (Medical Deans Australia and New Zealand 2015). In 2017, 12% of the active surgical workforce were women while 22% of those who achieved Fellow status that year (i.e. became surgically qualified) were women (RACS, 2018b). Due to the relatively limited understanding of how women account for their experience of gender and surgery as a specialist medical career (for an exception, see Webster et al. 2016), we adopted an exploratory qualitative research design. However, the interview protocol was informed by existing literature on how women experience the gendered contradictions that underpin their inclusion in male-dominated professions, including surgery (e.g. Hatmaker, 2013; Cassell 1996; Wright 2016).

Eighteen semi-structured interviews were undertaken with both Australian and New Zealander female surgeons, with participants ranging across the span of a surgical career, from those who were recently inducted as Fellows to those who had been practising for decades. We recruited participants by circulating an advertisement through the ‘Women in Surgery’ committee of RACS. Some women responded directly to this call but others were the result of snowball sampling from those already interviewed. As it is a very small population, providing demographic details could make our interviewees identifiable, however, we can report that six of the nine RACS specializations were represented, and fifteen out of eighteen of those interviewed had children.

Initial interview questions were open-ended, including questions around why participants’ studied medicine and chose to pursue surgery (Holstein and Gubrium, 2016). Follow up questions included querying the reaction of others when they expressed an interest in a surgical
career. The interview also included discussion around dealings with medical students and trainees, as well as exploring any stereotypical attributes associated with surgery, and the definition of a ‘good’ surgeon. The final stage of the interview drew on participants’ direct and indirect experience of gender in the surgery profession, with follow up questions including the necessity of intervention and their observations around the experience of other female surgeons.

Interviews with participants took place by phone or face-to-face, depending upon the availability, location and preferences of the interviewee. All interviews were audio recorded and transcribed with participant consent. There were several rounds of iterative analysis of the interview transcripts where we moved between describing patterns, interpreting data and comparing with previous relevant literature on women in STEMM professions (cf. Ladge et al., 2012; Mavin & Grandy, 2016). Initial codes were developed separately by the authors to identify patterns of similarity and variation around the interview questions, then compared and refined. This included codes based on interviewees’ accounts of gender stereotypes and surgery, the relevance or non-relevance of gender in their career, whether they had experienced gender as problematic, how their gender affected the ways others interacted with them, their experiences or opinions about combining surgery with parenting. We were able to ascertain that there were commonalities across our interviewees’ accounts of their experiences of gender and surgery, but also sufficient difference and variation that, while numerically small, our sample was sufficient to provide both “depth and breadth of understanding” (Corbin and Strauss, 2008, p. 149). Based on these initial codes, we attempted to develop some higher-level categories that arose when women occupied the surgical role that reflected Davies (1996) argument that profession is premised on the suppression and devaluing of the feminine. Revisiting earlier literature that developed this idea using examples of medical division of labour and caregiving led us to more systematically apply a ‘rationality of caring’ lens
(Waerness, 1984; Davies 1995) in our analysis, including the mechanisms and processes through which care was repressed. This enabled us to identify three fundamental gendered contradictions women encountered vis-à-vis the masculine professional ideal of a surgeon which form the basis for our findings section.

All interviewees are referred to by pseudonyms and some details disguised. This was particularly important because it was evident during the course of the research that gender was a sensitive issue, even for fully qualified surgeons:

“It's a disadvantage to stick out as someone who acknowledges gender differences... I can say it here because I'm not in front of a bunch of male surgeons.” (Hayley)

Immediately after our data collection had concluded, allegations of extreme incidents of bullying, harassment and discrimination were reported in the media which led to an independent inquiry by an expert advisory group (RACS, 2015). This resulted in a report with several recommendations to change the “toxic culture” where surgeons “eat their young” (Aubusson, 2017). While we do not focus on the content of this report in this research, it provided additional evidence of gender discrimination and systemic lack of care, consistent with the accounts generated in our interviews.

FINDINGS

We identified three main gendered contradictions in female surgeons’ accounts of their experiences of training, socialization and career relating to the repression of, but need for, care in their profession. The first concerned the processes through which they learned the surgical ethos of ‘toughness’ and independence; the second centres around women’s experiences of the contradictions of caring for others within the profession; and the third focuses on the
incompatibility between motherhood and caregiving outside of work on the one hand and professional legitimacy on the other.

Learning to be ‘tough’ and independent

The surgical ethos of individual independence and invulnerability (Cassell 1999) is reproduced through its training programs. Learning how to become a surgeon not only involves mastery of technical skill and knowledge but also extended processes of socialization through which the trainee becomes habituated to long hours, extreme fatigue and physical and psychological distress. Those we interviewed recalled this period as one of incredible hardship bound up with proving their commitment to superiors. Most described existing in a ‘bubble’ for years when they merely subsisted, exercising a self-discipline characteristic of ‘elite athletes’.

“We have a joke in orthopaedics that the training program is four years of low-grade nausea and humiliation. That basically sums it up. It’s exhausting. You spend four or five years of your life, maybe even longer, just being constantly sleep deprived, working yourself to the bone…. I don’t think anyone truly understands how bad the training program can be and it’s just a matter of survival and I hope that changes but I don’t think it will. I did six months in [place] where I was on call for six months; I worked 12 or 20 days straight and have two days off. That was operating until 2am in the morning every night and starting again at 6am…. ” (Rita)

It was not only the physical demands that took their toll but the culture of surgical training, characterized by negative reinforcement, belittling comments and harsh criticism, with positive feedback or encouragement a rare experience. If trainees were unable to acclimatize to this culture, they were judged unfit to continue or dropped out. One of our interviewees was the
first female at her centre to complete advanced surgical training; four women prior had started and withdrawn “It was just such a tough, brutal place” (Cecily). Another commented that in her surgical sub-specialty, they routinely took on more trainees than could be finally admitted and it was ‘always a girl who gets kicked off’ (Roseanne).

While trainees of any gender were subject to these same institutionalized practices and culture, the women we interviewed reported different and additional, informal ‘testing’ by superiors, a reluctance to modify practices to accommodate physical diversity and less social support both inside and outside the workplace. Several recounted repeated instances where they or other women were subjected to additional ‘hazing rituals’ by others to test their physical and mental toughness. For example,

“People having knee replacements tend to be quite heavy. On one occasion I was left holding the leg for about 40 minutes while the anaesthetist and surgeon chatted, waiting to see if I was going to put the leg down and complain. I was equally determined that I wasn’t.” (Fiona)

Withstanding such behaviour was seen as an important part of proving they were worthy of being on the program.

Small modifications that would accommodate the physical diversity of women (e.g. such as the use of a clamp for smaller size hands in colorectal surgery) or lessen the impact on surgeon’s bodies were denigrated. Despite strong resistance to accommodating physical difference, some female surgeons implemented minor changes and taught these to others:

“I have no problem sitting down, I make everyone sit down… the tradition is you don’t sit down because it’s weak so I think, why? You know, for most things you can sit down. Yes, it is physically demanding and you need to know how to leverage off the larger muscles so when you’re doing the finer stuff you don’t have the pain in the
smaller muscles. There’s a lot of skill in being able to do that for a long time without getting muscle fatigue.” (Zoe)

Such measures seemed problematic because they indicated surgical bodies were not superhuman, but subject to the same limits as other bodies. Making such changes would also risk destabilizing the ‘hands-on’ ideology of surgery central to maintaining its heroic, masculine ethos (cf Faulkner, 2009).

Single-minded devotion to the profession was inculcated in trainees by the hours, intensity and unpredictability of demands which meant they always prioritized training, resulting in social isolation: “You lose your social life, you lose your friends, you lose any sense of community and it’s just all trying to get out the other end” (Celia). While all trainees were subject to these demands, this appeared to have a different effect on women because they were less likely to have partners who took responsibility for running the household making the demands of the program more bearable. One surgeon recalled being with a cohort of five other men, all married, who had a

“very supportive home environment. So all that extraneous noise that you have to worry about day to day like paying bills and doing grocery shopping and cleaning the house was all done for them. I think in that circumstances you probably have the capacity to keep on going as you are. But, some of us weren’t that lucky to have wives at home.” (Teresa)

Similarly, the system of rotating placements, where trainees had to relocate every six months, potentially vast distances at short notice and between Australia and New Zealand, was disruptive for anyone on the program. However, the surgeons we interviewed argued women were less likely to have (male) partners who were willing to follow them on placement, playing
‘second fiddle’ to their career, and were less able to form and sustain relationships in the first place.

Inside the workplace, women talked about their greater social isolation and difficulties in developing mutually supportive relationships. They could not participate in the informal debriefings after operations that happened between male surgeons and trainees that took place in the changing rooms. Once qualified, mixing socially outside of work brought added complications because of the possibility of “misinterpretation” (Hayley) and the reactions of colleagues’ wives and partners:

“Friendships on the job are hard… you don’t want to go out for drinks with [the other male registrars] too much after work and debrief because you don’t want to get their partner off side…. There’s that part of it, you don’t have that same comradery.”

(Eleanor)

Because there were so few female surgeons and registrars, it was unlikely they would be at the same hospital, so there were fewer opportunities to develop friendships with peers.

At the same time, they learnt not to expect the same level of support and care from others, often women, who performed ‘ill-defined’ (Davies, 1996) clerical and nursing work. Even within the same surgical speciality, the female surgeons we interviewed felt subject to different gendered expectations. As a result, when the surgeon was female, she did additional work including ancillary tasks normally undertaken by others. Resonating with Webster et al.’s (2016) findings, female surgeons recalled having to learn how to embody surgical authority and decisiveness while knowing they could not behave like their male counterparts, nor expect the same level of assistance from nursing and administrative staff. Some stressed the importance of developing a rapport with these other women, by showing a willingness to undertake more menial tasks male trainees and surgeons would not normally do.
“[Administrative staff] definitely expect us to be more reasonable… I triage all my own referrals, do all my own results, [the other male surgeon] has all of those physically carried by a receptionist and put under his nose to check.” (Molly)

If a female surgeon insisted on support, they described resistance on the part of other women who expected these surgeons, as women, should do this for themselves:

“I have to ring the theatre receptionist and say, [Tanya] could you please refill the stationery, I’m doing a high turnover list, I’ve got 12 cases and I don’t have any stationery. She’ll say, well you can walk to the stationery cupboard – it’s in the storeroom. I’ll say, Tanya come and restock the stationery. If the male surgeons ask, she pops in and sometimes she’ll make them a cuppa.” (Hayley)

While noting the inequity, some reframed this as an advantage – through necessity they had to learn how to be more self-sufficient and independent than male surgeons, because they could not expect to be ‘taken care of’ in the same way by female support staff.

The independence, detachment and ‘superhuman’ physical and mental toughness for which surgeons are known are cultivated through years of training and socialization and the systems which govern full admission to the profession are, on the surface, gender neutral. However, the women we interviewed provided insights into how gender exclusion is reproduced through the cultures of hospitals (cf. Crompton, 1987) and the processes through which professional competence is acquired. They appeared to enter the programs with a ‘legitimacy deficit’ because surgery was perceived as a gender in/authentic career choice. Moreover, there were also required to take on the adjunct, ‘invisible’ care work on which the medical division of labour is based, care work routinely provided by nurses and clerical staff to male surgeons. These other women were seen as potentially problematic by our interviewees, rather than a source of social support (cf. Wallace, 2014). Female surgeons’ status as ‘superiors’ was
therefore contested in many small ways, not only by men, but by other women in formally subordinate roles, who withdrew ‘personal services’ (Waerness, 1984) that supports surgeons’ work. It seemed as if women not only had to live up to the masculine ideal of independence but surpass it in order to survive training and function in hospital environments.

**Care of others at work**

In addition to habituating themselves to the physical and psychological demands of the profession, an important part of their training and socialization was learning to act like “you are the one in charge who knows what to do” (Molly). This involved being able to convincingly convey individual authority in interactions with others, synthesizing information quickly and confidently making decisions but also developing a detached and non-caring persona. To show ‘committed attending to others’ in interacting with patients, for example, risked being seen as less competent and suitable for a surgical career. For example, one surgeon said:

“I don’t actually think I was a female trainee. I think I was a male trainee, just in female form. Whereas those who behaved more like girls did struggle, insofar as they spent a bit more time on the ward coming to theatre, making sure that a patient, who is having a mastectomy, was understood and happy about what was happening. Spent more time talking to them about it – which we would all agree is a good thing to do, but it’s a very girly thing to do… She was penalized for that kind of behaviour.” (Joanne)

In this example, the surgeon recounts a strategy to survive training that could be characterized as suppression of the ‘feminine’. The other female trainee’s inability to ‘read’ the masculine ethic of surgery with its requisite detachment from the other, and understand the consequences of her ‘overly’ feminine behaviour, is constructed as the problem. In effect, the female trainee failed to become the type of ‘social man’ (Hatmaker, 2013; see also Cassell 1998, p. 118) consistent with surgical ways of being and behaving.
But even after becoming fully qualified, showing care and committed attending to others was problematic and antithetical to the professional surgical ideal. In one example, a surgeon recalled…

"At times you’d spend some time chatting to the patient, explaining what operation you’re going to do, what the side effects were. Then they’d say, ‘this Dr. X, is he any good?’ I’ve just spent 10 minutes explaining to you that I, Dr. X, am going to be doing this – ‘he’s bloody marvellous, we’ll be fine [laughs].” (Fiona)

Here the surgeon’s display of care towards the patient appeared to contribute to professional misrecognition. On the other hand, being known for ‘listening to’ patients could lead to high-demand in their private consulting rooms. However, the expectation that consultation would be a highly personalized and caring interaction also imposed significant extra work, making it difficult to manage their caseload and appointment schedules.

Women also faced the ever-present suspicion they would be unable to keep their emotions in check, and remain sufficiently detached and in control to perform critical, life-saving, risky or major surgery – all of which carried masculine associations and higher status (see Hinze, 1999).

“The stereotype is [females] go on and we do things like paediatrics and 'easy surgery', not the 'seven-hour chop somebody's head off and have them die a month later’ kind of operations.” (Anne)

The dramatic nature and risk involved fit the idea of surgeon as masculine hero, whose self-control and ability to act decisively in a crisis save lives. Women were therefore seen as particularly gender ‘in/authentic’ if they expressed a desire to pursue some surgical subspecializations such as vascular, oncology and neurosurgery:
“People find it really quite strange that I want to do cancer surgery ... they said we aren't really quite sure how you'd work out because no women have ever done this before. Like well for fuck's sake, what do you think is going to happen? I'd burst into tears as soon as I picked up a knife?” (Anne)

The cultural association between women and emotions thus seemed to be central not only to surgery being perceived as a gender in/authentic choice but also used to construct more nuanced gendered hierarchies among sub-specializations. And yet the women we interviewed reframed their ability to ‘handle’ the emotions of others as an advantage, compared to many male surgeons who were “unable to communicate, unable to give bad news, when the patient starts crying and they run in the opposite direction”. Instead they were “able to sit down and have a frank discussion with a patient and get to know the patient as well. Not be afraid if the patient is emotional.” (Judy)

Similarly, the women we interviewed recognized the culture and systems of surgical training were ‘care-deficient’. They saw the need for more care towards others, particularly trainees, students and junior staff. This was both more effective and required to sustain the profession and organizations in which they operated. But this view was not necessarily shared by those running the hospitals in which they had to secure a job. One surgeon recounted being interviewed for a consultant post and how the panel reacted when she challenged the norm of enabling bad behaviour among male surgeons towards students:

“in the interview questions, they asked about how you’d deal with a difficult colleague, who had been making medical students cry and had been unduly harsh on them, and, in a repeated way. You sort of say, ‘well you take him aside and you chat to him about what the real issues are and how it can be resolved. You might offer to take the students from him or whatever.’ The scenario went on and he was continuing to be an issue.
Part of the problem is that there was in fact one of those consultants at the hospital and had been for years. I broke in the interview. I said, look, at some stage, you just have to go and ask him ‘what on earth is he still doing in the public system?’ Suggest that if he doesn’t want to look after students and teach people, then he shouldn’t be in a teaching hospital. The look on their faces told me that I shouldn’t have said that.” (Stella)

It seemed to fall to the few female surgeons in the system to make up for a general lack of care towards the next generation of surgeons, care that was essential for the profession’s reproduction but which was devalued, rendered invisible and added to their workloads. Some reframed this imposition as an opportunity to practice surgery differently and contribute to others’ professional development:

“I do try very hard to not be that surgeon who makes life difficult so I tend to go a bit out of my way to try and encourage the opposite and people in general seem to respond really well to it…. I find it very strange that surgeons think they need to make it difficult for medical students”. (Diane)

By not conforming to the stereotype of surgeon-as-god, they felt students and trainees were more willing to approach them with problems enabling quicker resolution, an illustration of the ‘rationality’ (Waerness, 1984) inherent in their understandings of the care they provided. This affective feminine pedagogy (Tsouroufli, 2018a) involved added work such as providing ‘pastoral care’ to students and trainees, mentoring junior staff and serving on hospital committees.

“Well it is kind of like, if you’re at home there’s a dishwasher that needs to be unstacked, so no point in talking about it, just go and do it right? It’s the same sort of thing at work, you can see a need, you know, sit down with your trainee and talk to
them. You know, nobody is going to go to that meeting, or we’ll have no work representation so I may as well go. It’s a no-brainer I guess, but I guess the boys don’t feel that responsibility perhaps and they don’t really do the pastoral care stuff at all.” (Kim)

Yet the expectation that female surgeons will incorporate the suppressed feminine ‘caring’ mode at work, whether that be with patients or junior staff, risks them being overwhelmed by the demand for care and support in a system where this is needed but radically undervalued. The parallels drawn by our interviewees with domestic chores that similarly fell disproportionately to women suggests this type of work encompasses Waerness’ (1984) conception of caregiving for dependents but is perhaps more akin to the responsibility women often assume for the running of the home (see Hochschild, 2012). The extra load that female surgeons carry may thus not have a particular caregiving target, in the form of a person, but rather supports the functioning of the organization and the reproduction of the profession itself.

**Connection and caregiving at home**

Those around them, such as medical students, more senior professionals, and their own families, assumed female surgeons would bear the major responsibility for care in their own households. The surgeons we interviewed spoke of many occasions when they were told motherhood and surgery was essentially incompatible: they could either be a ‘social man’ (Hatmaker, 2013) or a mother but the latter would undermine their professional legitimacy:

> I even had open comments about well, which one are you going to be, are you going to be a man dressed up as a woman or are you going to be a stay-at-home mum who just does lumps and bumps; there’s nothing between the two.” (Lisa)

Being a surgeon and a mother was still so rare, some tired of their visibility as a role model:
“Every time I teach medical students, someone at the end of the week - or two or three - will cluster around me and say, “wow, so, a female surgeon. tell me, how do you balance work and kids?” You think, I don't know - how did your dad balance work and kids - why are you asking me? So, I know that they need to seek mentoring, these younger women and men, but I also - I'm just - there's only so many times… you want to have a stamp on your forehead saying, ‘only person in Australia balancing work and family, because I'm female.’” (Hayley)

Some women recalled being questioned repeatedly about their family intentions from the outset of their admission and training:

“Interviewee: …at the end of my second year, somebody said ‘you know, do you still want to be surgeon?’ I said ‘yes sir’. They go, ‘you realize you can’t have any children?’ I go, ‘yes sir’, because they obviously thought that that wasn’t going to be compatible.

Interviewer: It’s interesting as well that you said yes to that.

Interviewee: I knew that he wouldn’t have coped if I’d said, ‘well sir, I think there’s a way around it’. Later on in my career, one of my bosses goes, ‘the best thing about you is you’ve had children and done everything and you never stopped working’. I thought ‘no, I did stop working, but you weren’t inconvenienced so you don’t remember that I stopped working, because I organized cover for my job when I was a consultant and took time off.” (Kate)

Here the interviewee was not only aware of the contradiction between surgery and motherhood, but deploying a strategy of not openly challenging her superiors, organizing her commitments to avoid any disruption and minimizing the visibility of her motherhood. Overall, however, combining surgery with motherhood was extremely difficult. Similar to Blair-Loy’s (2001)
discussion of the family devotion model that persisted even among professional women with demanding careers, female surgeons wanted to be ‘real mothers’ and do the household caring work for family. In this way they attempted to ‘absorb… the conflicting demands of home and work’ (Hochschild. 2012, p. 203), pushing themselves beyond normal physical limits in surgery, and then doing a ‘second shift’ (Hochschild, 2012) caring for others, once they returned home. For example, one interviewee told us:

“Surgery is really hard on your body. I had – last year I had a problem with my neck, a disc went and my hand became paralysed actually while I was operating one day. And I needed to have surgery on my neck to fix that. And so, like many surgeons, I have neck pain and back pain… you spend a lot of time standing which is fine, but really you spend a lot of time kind of hunched or with your neck – on Monday, the case I did with my colleague, it was four and a half hours, it was extremely difficult, I was completely focused the whole time, it got dangerous- in terms of dangerous for the patient- when I got home my body was so sore, I just lay on the couch for an hour, cooked dinner for the family and then I lay on the couch for an hour, I couldn’t do anything, I was physically exhausted, and I assume that gets worse as you get older.” (Megan)

Despite her level of physical fatigue and injury, the surgeon does not appear to have considered ‘outsourcing’ dinner or being ‘taken care of’ (Hochschild 2012) by someone else, i.e. expecting care to be reciprocated (Waerness, 1984) so she was its beneficiary, rather than its agent. Using Hochschild’s (2012) terms, this surgeon employs a strategy of ‘supermoming’, which leaves her dangerously depleted but even she doubts her ability to sustain this strategy over the longer term. One surgeon without children, felt those who gave the impression you could ‘do it all at once’ were not being honest about the sacrifices and compromises required. Recollecting a professional development forum for medical students, she was angry some female surgeons…
“got up and gave this perfect picture of family life and how they have it all. I’m so, you’re all lying. This is not what they should hear. They should hear about all the difficulties… I’m like, two of you have live-in nannies, you barely see your kids… So they gave this false impression that they have it all and I think that puts undue stress on the others who think, oh my God, if I can’t have that, then I should – if that’s what you are giving as an example to live up to, I think it’s really unrealistic.” (Emma)

Here our interviewee is arguing being more open about their use of ‘outsourced’ household care would be more useful to students considering surgery because it would prepare them for the problems they were going to encounter and be less likely to blame themselves if they fell short.

Other strategies were also mentioned: a supportive husband or partner, willing to share household duties more evenly, made surgery and being a mother more possible, as did relocation to a smaller rural or regional centre. Some purposefully spoke about their children at work, to show it was possible to be a (female) surgeon with family; another described how her children accompanied her on ward rounds at times and how this altered the dynamics of patient-surgeon interaction. However, the strategy of ‘cutting back’ (Hochschild, 2012) at work through reduced hours was problematic because it put their professional legitimacy at risk:

“If you’re not stupidly busy so you’re exhausted every week, then you’re not trying hard enough…. I hear rumours from those who like me well enough to tell me, that there is that sense that I’m not a serious surgeon, because I don’t work full-time.” (Joanne)

Timing pregnancies and motherhood around surgical training and careers was a common strategy because it seemed particularly problematic to be pregnant while on the program, and not just because of the physical demands involved. For example,
“I know that there are female trainees that have – that continue training through pregnancies and through having babies. They have very supportive families and they do amazing work. I cannot imagine that I could have done that. It – the logistics, sure, you can do the logistics. That’s not a problem. The emotional caring would have torn me apart. I would never have got through training with that, I don’t think.” (Sara)

Those who had children during training experienced repeated negative comments, e.g. that they ‘obviously weren’t serious about surgical training or you wouldn’t have gotten pregnant again’ (Roseanne) and more pronounced abuse:

“I was screamed at by my surgical fellow for trying to pump off some breast milk before a long case one evening, because I hadn’t been home and I was trying to keep feeding. He absolutely hit the roof and said, I shouldn’t be a surgeon. Just lots of things like that over the years” (Judy).

This interviewee was known to have had two children during the course of her training, and only recently qualified. She still experienced challenges to her competence and legitimacy associated with her motherhood, recounting a recent incident where she was belittled by other medical staff:

“Just last year I was told I should go and do the grocery shopping, in theatre, in front of everybody. It’s still very prevalent.” (Judy)

Here the insult centres around the contrast and contradiction between the image of the elite technical expert who through ‘hands-on’ intervention saves human lives and the banal ordinariness of the everyday, ‘feminized’ caring work of household shopping. It is thus not just that both surgery and motherhood are ‘greedy institutions’ (Croser 1974 cited in Tsouroufli, 2018b) the dominant norms of which require physical presence, hands-on involvement and singular dedication. Rather these examples speak to a more fundamental
contradiction between the caring and connection motherhood involves with the detachment and independence underpinning ideals of surgical competence.

CONCLUSION

Surgery is an extreme case of a gendered high-status STEMM profession. The normative surgical stereotype is an independent, heroic individual completely focused on surgery to the exclusion of personal relationships and family life, willing and able to withstand physical demands ‘normal’ people either could or would not endure, whose skilful and decisive action can mean the difference between life and death. However, this ideal is also fundamentally gendered in a way that makes it difficult for women to occupy the surgical role. Their presence at once heightens, and makes more visible, the contradictions concerning care: both repressed and needed, it is devalued but never entirely absent and can resurface. Our findings show how female surgeons experience and absorb the contradictions between care and competence, structured into the profession and the way it reproduces itself.

Previous literature on women and surgery has identified problems combining work with motherhood, and the less favourable treatment they report experiencing in interactions and in formal and informal systems of networking, mentoring and performance evaluation (Cochran et al, 2013a, 2013b; Gerull et al. 2019; Lebares et al. 2018; Salles et al. 2018; Seeman et al. 2016; Wallace 2014; Webster et al. 2016; Tsouroufli 2018a, 2018b). Our study extends this body of work by explicitly applying a ‘rationality of caring’ (Waerness 1984; Davies 1995) lens to generate new insights. To date, this has mostly been used to explore issues within feminized care occupations. However, here we use it to analyse women’s experiences of an elite masculine profession whose ideals of competence are antithetical to care. Their presence makes the ideology on which the profession is based more visible including its contradictory
The repression of, and need for, care, both inside and outside the workplace. In particular, it allows us to understand more about the different forms care work takes, the processes through which repression of care occurs, (and therefore could be challenged) as well as the connections between the different experiences women recount that might otherwise be missed. In doing so, we extend Waerness’ (1984, p. 195) argument that caregiving involves rationality because it is “something which can be learned and for which there are rules for proceeding”. ‘Rationality’ also denotes an underlying logic, suggesting a system of beliefs “about how things are or how they ought to be” (Dean, 1995, p. 11). This underlying logic allows us to show how women both heighten and absorb the contradictions (Hochschild, 2012) between professional competence and care in ways that cross organizational and family contexts.

The first contradiction arose from the way women’s presence threatened to destabilize the masculine professional ideal of independence and detachment and the medical division of labour which sustained it. In effect, women had to develop a greater capacity for independence and self-sufficiency than observed in their male counterparts. Partly this was because they had to prove they were worthy of being and remaining on the training program and compensate for a seemingly gender in/authentic choice of career. But it was also generated through their disturbance of the ‘gendered order’ within hospitals whereby the routine, ‘caring work’ normally undertaken by clerical and nursing staff for (male) surgeons was not extended to them in the same way (cf Webster, 2016). In effect, their status as ‘superiors’ was contested and ‘personal services’ (Waerness, 1984) withdrawn. While Davies (1996) argued that caring and administrative work is the suppressed side of medicine, our research shows that when women occupy the surgical role, such suppression is destabilized. The result is that female surgeons absorb this contradiction by doing more of the routine feminized work needed for them to be able to operate.
On the other hand, they are expected to extend care to others at work but in doing so, their professional competence and legitimacy is at risk. This is the second major contradiction they absorb. They took this risk partly because they can see that ‘caring work’ was needed, whether that be spending time talking to a patient, membership of committees or ‘pastoral care’ of students, trainees and registrars. It was not that the inequity and gendered basis for this division of labour went unnoticed but it was likened to ‘housework’ – not valued but needed to keep the organization and profession functioning. Without it, the profession would continue to ‘eat its own young’, and consequently not be able to reproduce itself. In Hochschild’s (2012) terms we could detect both a ‘second shift’ of care work done by women outside the workplace, but also a ‘second shift’ within their paid professional roles. In other words, there was another layer of caregiving responsibility that women were expected to, and did, perform within their surgical roles that exemplified the profession’s contradictory need for, but repression of, care.

Outside the workplace, they employed various strategies to cope with the extreme demands of surgery and a ‘second shift’ (Hochschild 2012) at home. A few opted not to have children and many times, our interviewees recounted being told by those more senior that being a mother and being a surgeon were irreconcilable. And yet, fifteen of our eighteen respondents did end up having children. Analysing their accounts allowed us to reflect on why motherhood is seen as so difficult in this profession. Both are seen as requiring hands-on involvement, physical presence and undivided attention which creates time and resource constraints (cf Tsouroufli 2018b). The visibility of pregnancy and motherhood at work, and the extent to which this required modifications to practices or systems, seemed to be particularly problematic, provoking extreme reactions by those around them. While we do not want downplay the material problems of combining parenthood and paid work, we suspect this also suggests an ideological contradiction related to the repression of care. If we accept that the idea of profession is based around a masculine ideal of the detached, separate, agentic individual in
the public sphere then pregnancy and motherhood are an unequivocal reminder of that which is suppressed by this ideal: dependence (not independence), relation and attachment to others (not detachment), vulnerability and the everyday provision of care and caregiving work done to support families. This is not the territory of the exceptional and heroic individual but the banality of the ordinary and everyday: as long as they exist in a gendered binary, how can a person inhabit both without ‘undoing’ the elite mythology that underpins the first?

Thirty-five years ago, Waerness (1984, pp. 202-03) argued that women were experiencing ‘dual lives’, not only in terms of their paid and unpaid work but within each domain, having to “cope with the antithetical expectations of instrumentalism and expressiveness”. While her focus was feminized informal and formal care work, we have shown how her ‘rationality of care’ lens can help to unpack the contradictions women face in elite masculine professions, where these antithetical expectations are heightened. While some of these women were challenging the continued repression of care within the profession, this seemed to create more, not less, caring work for them, work that was invaluable but not recognized as such. Their presence made the contradictions surrounding professional competence and repression of care more visible, but it also resulted in them absorbing the contradictions into their workload to enable social reproduction whether this be of the profession itself or of their own families.

Our study certainly has limitations: we were only able to interview eighteen female surgeons and so our findings are based on those who were able to survive the training program and gain full admission. Clearly there is another population of women who withdrew, were ‘kicked out’ or who self-selected out at even earlier stages. Future research could focus on exploring the accounts of these women as well as younger men. Current cohorts of male medical students and surgical trainees may want more work/life balance and to take a more active parenting role which may present its own challenges to the traditional masculinity underpinning surgery.
We also recognize that surgery constitutes an extreme case - the antithesis of feminine caring – but in our further development of the idea of a ‘rationality of caring’ (Waerness, 1984) we have demonstrated its potential to be applied to women’s experiences of elite professions. While these professions may repress care and devalue the feminine, the forms this takes will differ depending on the specific masculine ideals which underpin each one. We suggest future research focus specifically on those sub-specializations within elite professions that have proven the most intransigent in their ‘sex-typing’ (Milkman, 1983), such as litigation within law. A ‘rationality of caring’ lens can help to analyse the specific form gendered contradictions between care and competence take in different professions and how different aspects of women’s experiences are underpinned by a common logic that unless critically unpacked, risks remaining entrenched.
*Women’s Studies Quarterly*, 17, 75-86.


Tsouroufli, M. (2018a). ‘Playing it right?’ Gendered performances of professional respectability and ‘authenticity’ in Greek academia. *Journal of International Women’s Studies*, 19, 6, 53+


