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Comprehensive Study on Gender Discrimination Against Female Physicians and its Impact on Healthcare

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Master's thesis

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Title: Comprehensive study on Gender Discrimination Against Female Physicians and its Impact on Healthcare

Abstract:

This study investigates the existence of gender discrimination against female physicians. With the increase of feminisation, it is relevant to explore why it is perceived as negative. Gender discrimination is explored in its different forms, such as opportunities to develop professionally and sexual harassment. Gender relations impact the distribution of power imprinted in all structures. The study, therefore, focuses on three levels, which can be reflected in the power distribution based on gender, individual, interpersonal, and institutional. Further, the impact of gender-based discrimination and gender bias on the motivation of young female physicians. This research employed mixed methods combining the use of qualitative and quantitative data that are set in socio-cultural context of the Czech Republic.

Quantitative data revealed that young female physicians often experience gender-based discrimination in employment, opportunities, wages, and respect. The study found that 22.76 % of female physicians experienced sexual harassment. Through the feminist theory the unequal gender relations were set in a socio-cultural context that illustrated the subordinate position of women.

The study explored the impact of gender discrimination on young female physicians on their aspirations to pursue leadership positions. The obtained data provide insight into gender discrimination and the aspirations of female physicians; however, the qualitative data could not prove causality. The assessed questionnaire can provide a useful tool for future studying of such issues, also allowing to see a change in the motivation among young female physicians.

Content

I would like to thank my family, friends, my partner, and my therapist.

I could not do it without your support.

Introduction

Women make up to 60 % of graduates of medical faculties in the Czech Republic and 54 % of physicians (ČSÚ, 2022). However, gender discrimination in healthcare does not receive much attention (Mladí lékaři, 2020). The Association Mladí lékaři (2020) highlighted the issue of gender discrimination in the context of staff shortages in Czech healthcare. Their data showed that female physicians' experience with discrimination impacted their decisions to leave or stay working in the hospital after attestation.

The existing research about the experience of young female physicians in Czechia focuses mainly on the work-life balance (Simerská 2000, Bauerová, Křížová 2006; Krejčíková 2005, Křížková a kol. 2011, Slepičková & Šmídová 2014), some researchers (Křížková et al., 2011; Křížová, 2006) explicitly point out the issue of gendered segregation resulting in men receiving leading positions. This study presents data about the distribution of responsibilities for care and household work among men and women to understand the sociocultural context of gender roles in Czechia. The Gender Equality Index shows that 67 % of women in Czechia take care of household chores and cooking daily and 16 % of men (EIGE, 2021). A study from Czechia highlights the impact of gender contracts, which affect women's position in the family and their careers. Women often judge their professional decisions based on how they fulfil their role as mothers (Simerská, 2000).

The gender pay gap can be a tangible result of gender discrimination. However, the gender pay gap among physicians between 25 – and 30 years is 12 %, even though the average age of first-time mothers is 28.8 years old (ČSÚ, 2019). Maternal and parental leave can serve to legitimise the disadvantaged position of women. The biases and discrimination are present and affect women even before they have children; perhaps during the studies, they experience sexist commentary (Mladí lékaři, 2020). The question of care and gender roles is relevant due to the low number and low accessibility to day nurseries and other forms of care for children younger than four years (Bryndová, a další, 2023). The thesis describes the systemic conditions of parents. The parental leave can be up to three years, impacting the possibilities of a parent who returns to the labour market, which 98.2 % concerns women (MPSV, 2022). The Czech sociocultural context shows a framework for understanding the position of women on the personal, interpersonal, and institutional levels.

The research set in other countries explores variable aspects connected to gender discrimination of female physicians in different fields of specialisation. The theoretical framework presents phenomena such as bias (Holliday et al., 2018), discrimination during education and training (Meyerson et al., 2017; Spina & Vicarelli, 2015; Yaghmour et al., 2021), and sexual harassment (Cortina & Areguin, 2021; Křížková, a další, 2006), illustrating the presence of gender discrimination in different medical fields.

The thesis further explores the outcomes that discrimination against female physicians has, such as the gender pay gap (Gottlieb, 2021), equal pay (Šimáčková et al., 2020), their chances to achieve leadership roles (Newman, 2011) or the impact it has on their mental health (Yaghmour, a další, 2021; Spina & Vicarelli, 2015). Young female physicians experience discrimination and biases, which affect not only the gender pay gap but also their professional aspirations (Simerská, 2000). The theoretical framework serves as a basis for the hypothesis of this study.

1. Young female physicians experience gender-based discrimination.
2. The experiences affect their motivation to aspire to or reach a higher position.

The study aims to explore the scope of gender-based discrimination among young physicians and the effect on the aspiration of female physicians. This study studies discrimination from an intersectional perspective, focusing on the impact of physicians' gender and age. Young professionals are in a specific position in the labour market; for young women, it can be a more vulnerable period due to the expected childbearing.

The hypothesis is studied through quantitative data collected in surveys from 337 respondents; 292 are women about their personal aspirations, views, interpersonal experiences with discrimination and bias, and the institutional setting to accommodate space where people are not discriminated against or feel safe to address discrimination. Further qualitative data in the form of short testimonies about experienced forms of discrimination additionally provide a tool for assessing the hypothesis.

The goal is to explore the systemic position of young female physicians and their experiences with interactions with colleagues, patients, leadership, and the institution. The study highlights the main areas in which female physicians experience discrimination. This study explores understudied topics in Czechia. With the long-term tendency of feminisation of healthcare, it is relevant to study why and in what areas half of physicians are more likely to experience some form of discrimination.

1. Empiric review

1.1. Information about the Czech Republic's healthcare system

The Czech healthcare system is financed mainly from public sources, which 2019 was 85 % of health expenditure, and the rest came from private sources (Alexa, a další, 2015). The health insurance funds are responsible for providing sufficient care for their members.

Czechia is below the European Union average on the number of care beds and primary care physicians (Bryndová, a další, 2023). The overall number of physicians is above the EU average; Czechia has 407 physicians per 100,000, whereas the EU average is 389 (OECD, 2022).

The insufficient number of physicians and other personnel in healthcare is affected by several aspects, such as the ageing of qualified staff (Bryndová, a další, 2023) or migration of healthcare workers (Wiskow, 2006)

The layout of primary and specialised outpatient providers is not spread evenly around Czechia (Maláková, 2022). Even though the patients are free to choose healthcare facilities, the accessibility, especially in peripheral regions, is limited and depends on the mobility of patients and their possibility to commute to see specialist (Bryndová, a další, 2023). Perhaps Prague has the highest density of all outpatient care specialisations (ČSÚ, 2010). Inpatient care is available through referrals or in case of emergency directly. Hospitals in small cities provide a limited number of medical specialities. Larger hospitals with broader specialisations are situated in urban areas (Bryndová, a další, 2023).

1. 1. 1. The development of Czech healthcare sector

Due to the historical development, healthcare workers in Central and Eastern Europe have lower status and pay than their colleagues in Western countries. Another challenge that post-communist countries face is the „credibility crisis of trade unions and the under-developed roles

of professional associations" (Healy & McKee, 1997). These aspects affect the ability of healthcare workers to negotiate their conditions and wages.

Since 1970, investment in healthcare improvements has slowed or even decreased. The economic transition after 1989 had a legacy of low investment. Such development led to neglected primary health care in the 1990s (Healy & McKee, 1997). The staff in polyclinics was paid down, and low-status physicians did the services. Meanwhile, medical specialisation was encouraged and funded extensively. The specialists in Czechia provide high-quality care.

The positive impact of the historical development of the Czech healthcare system is the universal entitlement to the full range of health services. However, the services or quality content is distributed differently (Healy & McKee, 1997).

1.1.2. Historical overview of women's entry into the medical profession in the Czech Republic

Men have historically dominated the physician profession; however, women comprise over half of them. The development of the healthcare system and the place for women was started by Anna Honzáková, who graduated from the medical faculty as the first woman in 1902 in Czechia. She became the first graduate physician (Tomeš, 1999). From 1906, she was the chief surgent and director of the hospital in Hradec Králové (Svobodný, Hlaváčková, 2004). Throughout time, the number of female physicians grew. "In Czechoslovakia, the predominance of general practitioners persisted until 1988, and the representation of women exceeded 50% a year later. Currently, we have over 29,000 female physicians, who outnumber men by a ratio of 3 to 2."(Cholevová,2023) Data from 2019 show that 54 % of physicians are women (ČSÚ, 2021). In 2005, there were 50 % female physicians: in 2010, 52 %. The growth of female physicians is visible in the number of medical students in Czechia during 2005 – 2020, which moves around 59 – 60 % (ČSÚ, 2019).

The post-communist countries had earlier and higher rates of women participating in healthcare (Healy & McKee, 1997) Health Sector Reform in Central and Eastern Europe. The healthcare staff in Czechia is 80 % women; however, most women are nurses, and female physicians occupy low-status posts in primary care. „More specialised prestigious posts, such as chief of surgery, are as in the West dominated by men, "prestigious posts also mean higher salaries.

After the revolution, childcare and related social benefits became less accessible. Initially, during the regime, the system allowed women to work even in areas previously limited to men. However, such change targeted to support the economy, not the women's emancipation. It forced women to undertake the burden of paid work and family care. After the support system eroded, the double burden became more difficult for women to manage (Healy et al.,1997).

1.1. 3. Training of physicians

The Ministry of Education, Youth and Sports (MŠMT) establishes educational standards and training guidelines for aspiring medical professionals—university programs for medicine span six years. General medicine can be pursued among eight medical faculties.

Upon graduation, Czech physicians begin specialised training in hospitals. Each specialisation entails specific requirements concerning training duration, rotations, and procedure quotas. The completion time for these specialisations varies from 3 to 5 years, with cardiac surgery and neurosurgery requiring six years (Bryndová et al., 2023). Most of the specialisations require more general exams during specialisation, approximately after 30 months; this depends on the

willingness of the employer to fulfil the mandatory rotation in the given period. After completing the specialisation training, graduates must pass the state licensing examination (estate) to attain the ability to practice independently as physicians (Stará, 2012).

All physicians are obliged to continuous and lifelong education by Act No. 95/2004 Coll. This responsibility primarily falls on employers (self-employed individuals must organise it themselves), extending to all health professionals (Stará, 2012).

Larger healthcare institutions generally exhibit hierarchical structures, with senior physicians (primář) overseeing wards and state-run facilities linking years of service to salary, partly resembling the system for civil servants. However, senior positions or increased compensation are not guaranteed solely by seniority. Promotions and career advancement depend on personal merit, ambition, and approval from superiors or institutional boards (Bryndová et al., 2023).

1.1.4. Challenges of (young) physicians

Overtimes and nightshifts

The association Mladí lékaři shared a survey which answered 465 physicians in 2023 about the issue of overtime and night shift (Mladí lékaři, 2023). The results highlighted that the public health system functions due to excessive overtime of physicians. This problem concerns most physicians in hospital facilities, especially in smaller "district" hospitals. The results showed that 88 % (493 out of 560) of respondents' monthly overtime exceeds the statutory maximum of 30 hours; the average overtime was 77 hours (Mladí lékaři, 2023).

Another related problem is the length of the working day. The Labor Act No. 262/2006 Coll., § 83 states that the duration of a work shift must not exceed 12 hours. However, the night shift follows the working day; therefore, the average duty period during this shift was 26 hours. The estimation does not consider all weekend shifts from Friday to Monday noon due to the failure to record them, leading to an underrated assessment. These extended weekend services are mandatory in certain medical facilities.

The association Sekce mladých lékařů ČLK pointed out that pregnant women are pressured to take night shifts (on average 26 hours), even though the Labour Code forbids employers to employ pregnant women in overtime, which working days longer than 12 hours is. Pregnant women are directly coerced to work nightshifts by the management due to a lack of staff. Secondly, they are pressured through their wage. Overtimes makes up half of a physician's income (Sekce mladých lékařů, 2023). Public healthcare provides Equalization allowance during pregnancy and maternity to ensure women, for financial reasons, do not decide to work in unsuitable conditions for their pregnancy.

Nevertheless, Sekce mladých lékařů ČLK highlighted that the management of some hospitals does not sign the form for the Equalization allowance, coercing pregnant physicians to work night shifts or to accept lower income for several months prior to birth. This information is informal since the topic is not discussed in media or politics. However, the Sekce mladých lékařů ČLK started to collect data about the experiences of female physicians with such treatment in August 2023.

Generally, the compensation for overtime presents a broad problem, as Mladí lékaři found out in their survey. In some workplaces, the system of reporting overtime is called standby work, i.e., physicians are only paid 15% of their hourly earnings instead of their total hourly wages plus bonuses. Overall, 20% of respondents answered positively to the question of reporting overtime as on-call, and 16 % of physicians responded to this question with "I do not know,"

which shows that physicians often have no idea how they are compensated for overtime work (Mladí lékaři, 2023).

In addition, overtime work was often not reflected in employee compensation (i.e., financial evaluation of vacation, sick leave, and even overtime work). At the same time, wages were higher for full-time contracts, which affects, for example, the amount of maternity pay (Mladí lékaři, 2023).

The survey also shows the impact of overtime on physicians. Physicians most often described fatigue, long-term mental and physical exhaustion, a feeling of burnout, and health complications. Furthermore, they reported impaired concentration during services lasting more than 24 hours, and in connection with night services, they cited a higher error rate and the risk of harming the patient. Working overtime is why many plan to leave clinical practice or regret choosing that career.

Financial remuneration was the most important motivation for physicians to work overtime and on-call. The basic income is disproportionately low without services and does not allow physicians to provide for their families. Further, they mentioned collegiality towards co-workers. In third place, the respondents cited a lack of staff as a motivation for working overtime. The respondents expressed dissatisfaction that public statistics about physicians' income in the media do not indicate the basic salary of a physician but the earnings, including overtime and on-call (Mladí lékaři, 2023).

In June 2023, the Parliament debated whether to amend the Labour Code, increasing the allowed overtime for physicians and paramedics for five years. The authorised overtime would be between 8 to 12 hours weekly (Mladí lékaři, 2023). The chairman of the Senate Health Board, Roman Kraus, argued that 416 overtime hours are current practice. If the amendment is not approved, many smaller medical facilities cannot operate continuously (Zdravotnický deník, 2023).

The discussed amendment was in practice from 2008 until 2013 (Mladí lékaři, 2023). This period was supposed to serve the Ministry of Health to resolve the issue of the shortage of medical professionals. The step rose a reaction in the form of protest. Czechia is not the only country with such an issue; overall, 15 EU states allow more overtime in healthcare than the average of 8 hours per week. However, such countries also have a maximum limit of overwork time that can be maintained.

The mental health of physicians in Czechia

Work in the healthcare sector represents a highly stressful work environment for workers in terms of work content and work conditions. The consequences of emotional stress, pressure to perform, environment of the institution, high responsibility and low time flexibility associated with the profession of a health care professional can result in several negative consequences on mental health.

A survey among healthcare professionals showed that more than 70% of healthcare workers felt exhausted, 46.2% of healthcare professionals felt burned out, 33% of healthcare professionals suffered from anxiety disorders, 28% from depression, 37% from psychosomatic disorders, 17% with post-traumatic stress disorder, 20% abuse alcohol, medication, or drugs.

1.1.5. Does Czechia have enough physicians?

Even though Czechia has an average number of physicians compared to other EU states, as was shared earlier, the shortage of physicians is discussed in Czechia. The possible causes are explored in this section, together with challenges.

The lack of physicians is often attributed to the feminisation of healthcare. Women make up 80 % of all healthcare staff, nurses are 98 % women (ČSÚ, 2021) and 54 % of physicians are women (ČSÚ, 2021). The deficit of physician's public figures connects with the increase of female physicians. The president of the Czech Medical Chamber (Česká lékařská komora), Milan Kubek, said: „The continued feminisation of the field is a problem and another dangerous trend. Female doctors do not work as much because of family reasons. Just because a woman is a doctor does not mean she stops being a mother. "A cardiologist, Josef Veselka, called the feminisation of healthcare a problem, „In my opinion, it [feminisation] should be regularly addressed by the deans of medical faculties. The situation is not good for some branches, especially surgical ones. Such comments illustrate the sociocultural setting in Czechia; instead of adjusting the work conditions to parental responsibilities, women are perceived as threatening the healthcare system. Gender stereotypes and the spread of "full motherhood" will be discussed later, legitimising women's disadvantaged position, biases, and discrimination in the Czech healthcare system.

The COVID-19 pandemic opened a discussion about feminisation in healthcare. Media mentioned that female physicians and nurses are likelier to stay at home, while the education institutions for their children were closed during the pandemic. Gender contracts affected the division of family responsibilities when caring for children and sick or elderly family members. The effects of the double burden on women became more visible during the pandemic, alongside other issues connected to inequality.

Whether Czech healthcare had enough physicians emerged before the Czech Republic joined the EU. The ex-president of the Chamber and former Minister of Health, David Rath, commented that hospitals will be on the verge of closing within a year or two because of a shortage of physicians. However, joining the EU did not dramatically change the migration of physicians (Wiskow, 2006).

Around 1 300 graduates annually from Czech medical faculties (Bryndová, a další, 2023). Some graduates leave for other countries, such as Germany, where the working conditions or salary are more appealing. However, data about the healthcare workforce flow from the Czech Republic are not available (Wiskow, 2006; Bryndová, 2023). The only available data are from the Czech Medical Chamber, which estimates that 200 graduates leave for work abroad. The data comes from the number of certificate applications allowing physicians to practice abroad. These data are unreliable since it is unknown if the applicants leave the country.

On the other hand, joining the EU also secured an income for medical professionals from EU member countries, mainly Slovakia and Ukraine (Bryndová et al., 2023). According to Eurostat (2022), the inflow of physicians from third countries in 2019 was 105; in 2020, it was 138[1]. The state does not have a programme to recruit health workers from other countries (Bryndová et al., 2023).

Directive 36/2005/EC established the recognition of professional qualifications of health workers. The Ministry of Healthcare (MZČR) requires applicants to provide a formal

qualification certificate and proof of sufficient knowledge of the Czech Language Act no.95/2004 Coll. The process for non-EU physicians sustains from a two-staged process; the diploma must be recognised as valid and equivalent to the Czech diploma, then the candidate must pass the professional examination in Czech (aprobační zkouška) (Act no.96/2004 Coll.).

Another step to prevent young physicians from leaving was legislation passed in 2017, which should simplify postgraduate training – shortening the length of training, limiting required time in specialised training centres, and making accessible retraining for specialisation in case of shortage of specialists (Act no. 67/2017 Coll). The reasons students mention leaving Czechia for their postgraduate training are „higher salaries and negative experiences with the Czech health systém“ (Šlegerová et al., 2020).

1.2. Gender discrimination of female physicians

This chapter presents existing research on gender discrimination of female physicians in Czechia and other countries. A study by Simerská and Smetáčková from 2000 explored in depth the experiences of young female physicians in Czechia. This research serves analysis as a helpful tool to reflect on the institutional, interpersonal, and individual changes.

The text presents general issues interlinked to gender discrimination and bias experienced by female physicians, such as career setbacks, gender-based pay gaps, implications for patient care, and the psychological outcome of discrimination in the workplace.

1.2.1. Work and family practice of young female physicians in Czechia

Simerská and Smetáčková (2000) conducted qualitative research that mapped the work-family practice of young female physicians in Czechia (Simerská & Smetáčková, 2000, str. 61). The results from 20 interviews showed that established gender contract came in effect when female physicians were setting family and work balance in favour to family.

The research focused on the “professional self-assertation of young physicians about the family dynamics, the understanding of gender roles, harmonisation of work and family spheres, and gender specifics in the profession” (Simerská & Smetáčková, 2000). Young physicians shared experiences with gender discrimination and biases during studies and the hiring process; however, they often showed understanding and acceptance of their disadvantages, perhaps that men are more likely to be hired. These tendencies were attributed to the acceptance of gender contract, which functions on the family and institutional levels.

The European Commission (1998) defined the gender contract „as the explicit and implicit rules regulating gender relations and assigning different work, values, and responsibilities to men and women. “ (European Commission, 1998)

Simerská described that within the process of setting the work and family dynamics, the young female physicians applied the gender contract. However, they do not recognise being affected by it in their career decisions, their predominant role as mothers and caretakers in the family, or acceptance of discrimination in the workplace as something natural. The decisions about their career are legitimised by fulfilling the role of mother and, or wife, “Which for the young female physician meant most of the responsibilities for bringing up and providing for children, most of the housework and ensuring the running of the household.” (Simerská 2000, p. 50) The female physicians presented their compromise as a conscious and more or less free choice in favour of the family. They pointed to the social significance of women for family; it was perceived as “natural” and “necessary”. Maříková, Radimská (2r003) presents that a woman is

under social pressure to stay at home with the child, if possible, to fulfil their role of mother, while men are given the role of breadwinner.

This results in the lower professional ambitions of female physicians, which does not mean lower professional commitment. However, it led them to resign from pursuing higher positions or demanding better wages (Simerská, 2000, p. 50). Women take their future burden in the family into account when deciding on a field of specialisation, or during practice, they change their original plans and adapt their professional activity to the family's needs. Fields marked as unsuitable for women are also more prestigious and better rated.

The physician profession is demanding due to the need for continuous education, responsibility towards patients, long and irregular working hours, night shifts, and organisational issues in the healthcare sector. In the light of the described demands, such pressure on female physicians results either in suppression of the gender contract or, on the contrary, its more significant effect (Simerská & Smetáčková, 2000). The respondents shared that their situation was not solved through restructuring the roles in the family but through a compromise whereby a woman attempts to fulfil the requirements of both sides to a certain extent. However, being a good physician and mother (primary caregiver) was impossible, so they had to choose at one point.

In the professional area, the gender contract is supported by arguments that present specific disciplines as suitable or unsuitable for women; such tendency (discriminating practices applied on the labour market, not exempting healthcare) creates gender segregation within medical science.

The awareness about existing gender contracts among the respondents was either low or non-existent among the respondents. At some point in interviews, the female physicians mentioned mechanisms that disadvantage women; they queried that women would face discrimination at different points. The respondents share examples of discrimination; however, they rationalise the mechanisms as understandable on direct questions about it. For example, the experience with the hiring process included queries about when the physician would have a child or commentary that she would soon leave for maternity leave. The expected pregnancy and maternity leave affected the fact that women were not hired. However, the respondents described such experience with discrimination as understandable and reasonable.

The findings showed that women are more responsible for housework and childcare. Half of the women share in some form of housework and childcare with their partner, and half is doing them alone. It comes from a subjective description of the conditions, and the research does not offer data about how men feel engaged in housework and childcare. The physician profession is demanding time and expects continuous education. On the other hand, female physicians are affected by the disadvantageous household practice.

Female physicians seek a compromise between both roles; however, it was not resolved by adjusting family practice. Women’s decisions about their profession are legitimised by fulfilling the role of mother and wife. Young physician (30-35 years) tends to sacrifice more likely their professional role. The lack of capacity to care for children goes in hand with feelings of guilt.

The compromise in favour of family is supported by the arguments of the “social importance of women for family”. Women are more perceived through their role as a mother and men through their profession; the respondent describes this prisma as natural or necessary. This stance comes from the general understanding and upbringing. Such a perspective on women’s roles affects their lower professional ambitions. On the other hand, lower ambitions do not equal lower work engagement. “In the case of many female physicians, we witness a great

commitment to work, overcoming obstacles, significant qualifications achieved, and work placed high on the value scale. It is more about resigning for better job classification, achieving a higher position or for financial demands." (Simerská & Smetáčková, Pracovní a rodinná praxe mladých lékařek, 2000, str. 50)

Simerská described that the discriminatory practices in assessing candidates in the hiring process form gender segregation in medicine. Some disciplines are perceived as too demanding, physically or time-wise, and therefore are incompatible with the role of women in the family. Women consider their future roles while choosing their specialisation. The disciplines labelled unsuitable for women are usually more prestigious and better paid. Women, therefore, consciously go into fields where they do not have to compete with men.

Simerská highlighted that on the individual level, women perpetually interact with an interconnected world of social systems. The goal of an individual is to integrate into the social order while not losing individual integrity. Simerská continues to problematise the idea of sovereign individual subjects who have control over their lives and are the acting force. When the respondents present their choices about a profession in favour of family or experience with disadvantages but are shy to talk about discrimination or their role in the family, they do so about social norms. The "compromise" made on an individual level is motivated by sustaining a positive self-concept. The women are integrated into the socially accepted norms and tell their stories so that their integration would not be disturbed or questioned.

Unequal conditions in the labour market and the family were perceived as a woman's fate, which she must deal with independently. The respondents needed to have a perception of systemic issues and collective solutions and change. Simerská highlighted that the understanding and critical reflection of the gender contract is an essential step toward changes in the family and work practice of women professionals, including physicians.

1.2.2. Biases and discrimination of female physicians during medical education and training

A study (Holliday et al., 2018) showed that discrimination and harassment during medical training and medical school can discourage women from pursuing careers in specific medical fields. A study focused on the mistreatment of medical trainees from 1984 showed its outcomes leading to depression and faster burnout (Silver, 1984). Another recent study highlighted that *female and non-white students are more likely to report incidents of mistreatment* (Morisson & Fowler, 2020).

Gender bias refers to unconscious assumptions about individuals and groups which affect decisions about them (Holliday et al., 2018). It is interconnected with mistreatment, which Mavis defined as „denied opportunities, lower evaluations or grades, and offensive names and remarks predicated on gender, race/ethnicity, and sexual orientation " (Mavis et al., 2015, str. 706). Students and medical trainees are in a specific hierarchy; given their low experience in the medical field, age and status, they are more vulnerable to mistreatment, discrimination, and harassment.

Gender discrimination and bias exist at medical schools and continue through residency training (Spina & Vicarelli, 2015); for example, female residents receive fewer mentorship and opportunities (Yaghmour et al., 2021). Myerson described biases that disadvantage women in medical training, leading to different experiences for men and women during residency training (Meyerson et al., 2017). Meyerson's study focused on the effect of gender on autonomy given

to residents in the operating room and showed that women are given less freedom. The study highlighted the significance of the autonomy given to surgical residents to make decisions and exercise independence during their training, impacting their skills development and future careers. (Meyerson et al., 2017).

Meyerson highlighted studies that showed that women underestimated themselves, whereas equally skilled men overestimated their skills. The overconfidence supported bias favouring men (Reuben in Meyerson, Sternbach, Zwischenberger, & Bender, 2017). The research on laparoscopy supported this expectation - male residents expected better outcomes than their female colleagues, even if the results were equal. (Flucket, et al., 2017)

However, the lower confidence or underestimating of female physicians was impacted by previous experiences, with their underestimating connected to bias experienced by female physicians at medical school and during training (Meyerson et al., 2017; Morisson & Fowler, 2020; Yaghmour et al., 2021).

1.2.3. Workplace harassment, including sexual harassment

Sexual harassment represents one of the displays of discrimination based on gender and strengthens inequality between men and women in the labour market (Křížková, a další, 2006). Sexual harassment causes long-term stress, lower confidence, a negative impact on mental health, lower satisfaction with the job, and a higher tendency to change employment (Cortina & Areguin, 2021). A study conducted in the US found that women who experienced sexual harassment were 6.5 times more likely to change their employment than their counterparts without the experience (Cortina & Areguin, 2021). Both men and women can be subjected to sexual harassment. However, women experience it more often (Křížková et al., 2006).

Sexual harassment is a broad term that can include the scale of coercive behaviour, which does not have to be explicitly sexual, resulting in an unfriendly and stressful work environment. For this study, the definition presented in the EU directive 2002/73/EC. Sexual harassment: „where any form of unwanted verbal, non-verbal or physical conduct of a sexual nature occurs, with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment.“ (European Parliament, 2002) Due to the subjective perception of sexual harassment by the involved party, it is important to mention that the behaviour is unwanted.

Sexual harassment disturbs the integrity of an individual; therefore, it represents one of the forms of cultural devaluation of women as members of society. The androcentric setting enables it - centred around men and assigning them proactive roles and to women the passive role of an object of lust (Křížková, a další, 2006). Sexual harassment presents one of the mechanisms that strengthens gender inequality. Women who enter man-dominated fields experience harassment with sexual subtext more often. These women can be discouraged from entering or remaining in such fields, being forced to enter less prestigious positions or fields (Křížková, a další, 2006).

Sexual harassment can be perceived as a private matter. However, that ignores the crucial role of power relations in this issue. It can be „an expression of power and dominance and a mechanism for protecting or enhancing one’s sex-based social status. This conduct reinforces the existing gender hierarchy, a hierarchy that privileges men (explaining why men are more likely than women to harass sexually).“ (Bedahl in Cortina & Areguin, 2021, str. 287)

Cleveland & Kerst described different types of power which need to be considered when studying sexual harassment - organisational power and interpersonal power (Cleveland & Kerst, 1993). Organisational power is often described as an extension of societal power into the

workplace (Ragins & Sundostrom in Cleveland & Kerst, 1993). This approach lies in the gender disparities in formal status affecting the occupation of position and vital resources. Křížková supports this understanding by pointing out that sexual harassment relies on the division of power in society based on gender, affecting the number of men in leadership positions, instead of approaching it that it occurs due to the high number of men in leadership (Křížková, a další, 2006).

Cleveland & Kerst further describe interpersonal power, which focuses on the powerholder's behaviour and the target's reaction. Gender influences the perception of the appropriate use of power. Men displaying power over someone are more likely to be perceived as in place, including sexual harassment (Johnson in Cleveland & Kerst).

Women are vulnerable due to fear of unemployment and discrimination due to the load of responsibilities toward family; therefore, they are less likely to complain.

Research about sexual harassment in Czechia shows that 28 % of women encountered sexual harassment in their workplace– 13 % experienced it personally, 15 % witnessed it, 22% of men encountered sexual harassment - 4 % experienced it personally, and 18 % witnessed it. Women are more exposed to sexual harassment. Resolving the experienced sexual harassment depends on the resources and capacity of the victim. Most often, the situation is resolved by its other employees. The formal way of resolving sexual harassment with management is not so common (Křížková et al.,2006).

1.3. Outcomes of Discrimination against Female Physicians

This section introduces the outcomes of discrimination against female physicians, such as equal pay, career development and psychological and emotional implications. Further, the implication that discrimination of female physicians has on their patients.

1.3.1. Gender-based pay gap and salary disparities among physicians

„Even with women who have worked full time, have never had any time off, and have not had children because of their careers, there is still this unexplained gap.“ (Sally Davies in Rimmer, 2014)

The gender pay gap changes throughout the working years; it has existed since the beginning of a physician's career (Lo Sasso et al., 2020), even though people have mainly the same starting position in professional life and women are not (primarily) affected by birth and parental leave.

The gender pay gap is the average wage difference between all men and women in the labour market. The gender pay gap highlights the disparity in earnings between genders and is typically affected by a series of factors, including choices of areas, work hours, and systemic biases (Gottlieb, 2021).

Data shared by ČSÚ (Czech Statistical Office) confirms that the gender pay gap among physicians is present from the beginning until the end of their career. At the beginning of the productive age (25 – 29 years), male and female physicians have the smallest gender pay gap of 12 %, which rises by 1 % between the ages of 30 – 34. The average age of women with their first child is 28,8 years (ČSÚ, 2022). The most noticeable increase in the gender pay gap was at the age of 35-44 when women often go on maternity and parental leave. At the age of 35-44, the value of the gender pay gap grew to 32.7%; at the age of 45-54, it was the highest, at 34.3% (ČSÚ, 2019). An explanation of the continued income gap increase can be attributed to the

presumption that physicians 45-54 years old are at the peak of their professional growth, and the distribution of better-paying positions impacts the gender pay gap. From 55+ years, the gender pay gap is 22%, i.e., still a significant difference.

Researchers account for the gender pay gap in different aspects; for example highlighted different priorities based on the gender of physicians, mentioning that the professional attention of female physicians is on the care for patients instead of focusing on activities that would boost their career possibilities (Rimmer, 2014). Newman (2011) described that women are not as good at negotiating salaries. Men may also have better positions for negotiating since they are stereotypically perceived as the breadwinners (Newman, 2011). Also, women can more likely compromise on pay than men because they more often want to work part-time (Rimmer, 2014). Further, the gap can also be attributed to the fact that women often choose general practice over other specialities.

Gottlieb (2021) presented a guide for closing the pay gap. „Inequitable pay is a challenging juggernaut as it likely represents a convergence of all forces that diminish women's professional value within our healthcare institutions." (Gottlieb, 2021, str. 2) The interconnected components that affect the gender gap in salary are "equal access to resources and opportunities, minimising unconscious bias, leadership engagement, enhancing work-life balance" (Gottlieb, 2021).

Another phenomenon refers to different wages in the same position for the same work based on gender (or other characteristics such as age or race) (Šimáčková et al., 2020). The Labour Code n.198/2009Sb, forbids this to have an unjustifiable difference in pay between men and women who are doing the same work and have comparable skills, responsibilities, and working conditions. It is relevant to mention this phenomenon since the gender pay gap highlights the need to support women to have the possibility to achieve leadership positions (Šimáčková et al.,2020). However, with unequal pay, women who achieve higher positions carry another burden but are not compensated for it. The Czech labour code forbids unequal pay; however, in 2011, senior female physicians, upon leaving the hospital where she worked, discovered that men in a comparable position were paid up to twice as much, demanding justice in court. She lost the case, even though the labour code forbids unequal pay. The man who took her place received a higher salary than her immediately after taking over the position.

1.3.2. Professional and career development setback

A higher proportion of women successfully graduate from medical universities in Czechia; however, notable disparities emerge when considering the attainment of attestations. For instance, when obtaining first-degree general attestation after graduation, women comprise 64% of the total, while men constitute 36%. In contrast, the percentages shift significantly for second-level attestations, with only 32% attributed to women and 68% to men.

Women are underrepresented in senior management roles within the healthcare sector. Out of 201 hospital directors, merely 23 are women, as reported by ÚZIS ČR in 2002. These statistics prompt us to ponder why there is a substantial number of women in lower-level health positions but a scarcity in leadership roles. These statistics highlight the influence of gender stereotypes on how individuals assess the qualities of men and women, leading to the assignment of distinct characteristics based on societal perceptions of masculinity and femininity. Sandra Harding, in her exploration of the gender universe, argues that such characteristics play a significant role in shaping divisions of labour (Harding, 1986).

The number of women in leadership does not directly concern young female physicians, since at the age of 25-35, they have limited opportunities since most of them obtain attestation around 30-32 years. However, exploring barriers limiting female physicians' access to leadership positions provides relevant information about the barriers that young females may face. The low number of women in leadership impacts the low number of role models for young female physicians (Newman, 2011).

Research by Dr. Newman presented why fewer women are in leadership positions and the barriers on individual, interpersonal and structural levels (Newman, 2011). On the structural level, most articulated fear of triple burden- domestic, clinical and leadership responsibilities, and lack of role models. More women entered general practice because of more flexible and reduced hours than physicians in hospital (Newman, 2011).

The individual level, or "mindset", showed lower personal aspiration among female physicians; therefore, they were more cautious about applying for promotion or leadership roles. The female physicians felt disempowered; their impact was underestimated, and they were less likely to promote themselves. Achieving work-life balance was more important than achieving professional success. Female physicians experience, on an organisational level experience, unconscious bias, not being heard and being in a "boys' club". The cumulative disadvantage leads to a decrease in women's aspiration and possibility to achieve leadership position (Newman, 2011).

1.3.3. The psychological and emotional outcomes of discrimination

Discrimination against female physicians can have profound psychological consequences on their well-being. Research has indicated that women in medical training are more likely to experience depression, often caused by work and family conflicts. (Yamazaki, K, & Gruppen L. D., 2015) In some instances, female residents in medical specialities face additional hurdles due to the absence of partners who share childcare responsibilities (Holliday et al., 2018). Furthermore, the extended duration of medical training, which can last up to five years, delays the period when physicians can potentially enjoy a more flexible schedule and more significant financial means to seek domestic assistance (Holliday et al., 2018). This can impact their career choices and contribute to job dissatisfaction, limited communication with colleagues, and high rates of depression, burnout, stress, and dropout among female trainee residents (Yaghmour et al., 2021). To balance professional and personal lives, female physicians may adjust their expectations and settle for less than they initially aspired to achieve, potentially reducing job satisfaction and impacting their overall psychological well-being (Spina, 2015). The psychological toll of discrimination on female physicians is a complex and concerning challenge that warrants attention and intervention.

These adverse psychological outcomes are not gender-specific; however, they are exacerbated by gender discrimination and the demanding nature of medical studies and work (Yaghmour et al., 2021). Various factors, such as age, having children, specialisation, night shifts, and working hours, contribute to burnout, with female doctors experiencing higher rates than their male counterparts (Yaghmour et al., 2021).

1.3.4. Implications for patient care and healthcare outcomes

Discriminatory practices and biases that keep female physicians from entering and advancing in medicine can affect the healthcare system and potentially patients. Myers and Sutcliffe

(2018) describe that the result can lead to denying the patients opportunities to receive higher-quality care (Myers & Sutcliffe, 2018).

Evidence shows that female physicians deliver better care for patients (Myers & Sutcliffe, 2018). For example, a study by Tsugawa and Figueroa found that patients treated by a female physician had a lower chance of dying or being readmitted to the hospital within 30 days than those treated by male physicians in the same hospital (Tsugawa & Figueroa, 2016). The difference persisted even when the most common eight medical conditions and the comparable severity of illness. The study highlighted that those women were more likely to follow the clinical guidelines and evidence-based practice. It points to different practice patterns among female and male physicians (Tsugawa & Figueroa, 2016).

Another study focused on the outcomes of surgery by male and female surgeons supports the findings. Patients who female surgeons operated on were less likely to die within 30 days after the surgery. However, there was no significant difference between readmission (Wallis, a další, 2017).

Another aspect studied is the impact on patients based on their gender. A study conducted by Greenwood and Carnahan (2018) found that patients with sudden heart attacks treated by female physicians were more likely to survive than male physicians. The research highlighted that the most affected patients were women. Female physicians were more successful in treating female patients with heart attacks (Greenwood, Carnahan, & Huang, 2018). The survival rates were two to three times higher for female patients treated by female physicians than their male colleagues (Greenwood, Carnahan, & Huang, 2018). Women doctors respect and understand female patient's needs (Newman, 2011).

The reasons for different outcomes achieved by male and female physicians are to be further explored. Research suggests that female physicians follow evidence-based practice (Tsugawa & Figueroa, 2016), focus more on preventive practice (Henderson & Weisman, 2001) and communicate more with the patients. Studies also show that female physicians use more preventive care (Myers & Sutcliffe, 2018), have longer appointments, better communication skills, and a more patient-centred approach (Newman, 2011).

Male physicians who were more exposed to female physicians had better results in treating female patients with heart attacks (Myers & Sutcliffe, 2018). The presence of female physicians benefits patients and also their male colleagues. To hold back women from entering medical specialisations, gender discrimination, biases, and limited opportunities impact female physicians and the quality of provided medical care.

1.4. Sociocultural Factors

1.4.1. Sociocultural context: Examination of gender norms and expectations in Czech society

This section presents the Czech sociocultural context. First, the share of parental leave among men and women and its impact on parental employment is presented. To understand the possibilities of parents in the context of parental leave, the institutional regulations and support system for parents and families are briefly presented. Secondly, this section focuses on dividing household chores among Czech adults.

It is relevant to mention that even though some women do not plan to have children, the sociocultural context, which shapes the gendered perception and expectations, is reflected in this section.

1.4.2.1.Parental Leaves in Czechia

Czech is specific due to contradictory factors about women's position in society: the participation of women in the formal labour market is high (Formánková et al., Plasová & Vyhlídal, 2016; Bičáková & Kalíšková, 2015) and on the other hand prevails the traditional division of labour (Chramková et al., 2022). Parents on paternal leave are in 98.2% of women and men only in 1.8 % (MPSV, 2022). Formánková and others (2016) posed the question of whether such division of parental leave between men and women is given by economic rationality or cultural form (Formánková et al., Plasová, & Vyhlídal, 2016).

Czechia also has one of the most extended parental leave in the EU; 44 % of women stay three years at home with a child (Bičáková & Kalíšková, 2015), and 27 % of Czech mothers stay over three years (Formánková et al., Plasová, & Vyhlídal, 2016).

The welfare support system for parents consists of these main parts: the protection of employment during parental leave (Holdinská, 2015) for up to three years. Another form of support is "financial support during maternity." It aims at women starting six weeks before the expected due date and altogether 28 weeks. Financial support is provided for the mother or father (or a caretaker) to care for the newborn child. However, the father or husband can receive financial support during maternity only after the first six weeks after the birth because that period is dedicated to the woman. In 2018, financial support for fathers (otcovská) was established to allow men to care for newborn babies for 14 days (ČSSZ, 2023. Financial support for mothers prior to and after the birth and for fathers is provided by public health insurance. Therefore, only those who worked for a given period are eligible to receive the support, specifically, women who worked at least 270 days in the past two years. The financial support depends on the income and is 70 % of the person's income in the past two years (ČSSZ, 2023).

Next is the parental allowance, which does not depend on the previous income of the parents. The total amount of parental assistance is 300,000 CZK per child (around 12 607 EUR), which can be drawn between half a year and the child's fourth birthday (ČSSZ, 2023). The parent receiving support on parental leave can work full-time. This provision acknowledges that living without parental assistance for three years is possible. The state does not provide day nurseries, and few private ones exist. This policy supports the expectation of „full-motherhood ". Women who want to return to work can do so, and parental assistance can provide money to cover costs for day nurseries; this is an assumption on why the working parent is eligible for parental allowance.

On the other hand, the child cannot spend over 92 hours per month in a day nursery while younger than two years (MPSV, 2023). The incoherence of the approach to parental assistance illustrates the Czech systemic approach to parental support. Parents chose to work for several reasons, such as economic, not to stay out of the labour market for too long and were not disadvantaged (Křížková, a další, 2006).

Czechia is one of the EU countries with the lowest use of childcare services for children aged 0-2 years – only 2% of parents of small children use them due to a limited number of such facilities and an accessible price (Holdinská, 2015). There are no public facilities for children up to 3 years. Generally, the lack of nursery institutions negatively influences the possibilities for women to return to the labour market earlier (Formánková et al., 2010).

1.4.2.2. Employment after parental leave

Women experience persistent disadvantages in the labour market in employment and earnings (EIGE, 2022). Women are also affected by the fields in which they work and what contracts they receive. Women are more likely to work part-time, have temporary contracts (Eurostat, 2022), and be unemployed. Women's careers are further affected by childbirth and parental leave. The described affect the earnings of women throughout their life, to pension. Czechia received in Gender Equality Index (2022) in the area of work 67.1 points (out of 100) and decreased by 0.3 points (EIGE, 2022).

The report shows that 26 % of women are employed in education, human health, and social work, compared to 5 % of men. In the Career Prospects Index, women have 61 points (out of 100), whereas men have 65 points. The gender gap decreased by two percentage points to 16,4 % (EIGE, 2022)

The patterns of parental care in Czechia impact higher unemployment rate among women; precisely 30 % of women with children under three years and 60 % of women with three-year-old children become unemployed as soon as they return to work because employers are no longer bound to keep the previous position for them (Bičáková & Kalíšková, 2015). To illustrate the negative impact of parental leave on the position of women, it is relevant to reflect that Czechia is one of the EU countries with the most significant difference between the employment rates between women with and without children (Bičáková & Kalíšková, 2015). Women with children are also perceived as the primary caregivers and, therefore, responsible persons in the case of their sickness, expecting absence from work and limitations in managing their workload. Such presumptions can lead to a higher risk of unemployment (Bičáková & Kalíšková, 2015).

The Czech labour code provides a series of laws protecting parents. However, the practice differs. Such an example can be laws about part-time work, particularly those needing to care for family members. Studies show that part-time employment is uncommon in the Czech Republic (Holdinská, 2015). Employers are generally reluctant to agree to reduced working hours. Parents, primarily women, are limited to returning to work part-time; however, to return full-time can be out of their reach due to the costs and accessibility of the day nursery. Returning to a full-time job when the child is three or four years old is easier because the chance to get in kindergarten is higher. When caring for elderly family members, it is even less common for employees to ask for reduced hours to provide care (Holdinská, 2015). The mentioned law provisions focused on working hours are gender-neutral. However, 75 % of part-time workers are women (ČZSÚ, 2012). The reasons why people work part-time were in 2018 research „not finding full-time employment" (26%) and „taking care of a child or infirm adult" 24 % (ČSZÚ, 2018).

1.4.2.3. Division of household chores

Several generations in Czechia experienced double income. However, the transformations in gender roles, especially in the division of household chores, do not reflect that both parents work and women usually carry the responsibilities for care and household. Only the generation that socialised after 1989 showed a slow shift in the views on equality (Chramková et al., 2022). Research conducted in 2015 showed that mainly women were responsible for household chores such as cooking, cleaning, and childcare, except for maintenance and repair work (Chramková et al. et al., 2022, str. 344). Women spend, on average, 4 hours more per day on unpaid work than men. It is affected by the fact that women are more likely to be on parental leave; however, summed-up hours of paid and unpaid work still showed that Czech men work one and a half hours less per day than women (Chramková et al., 2022). Chrámková (2022) explored the

division of household chores together with the attitudes of Czech people towards gender equality. “Specifically, 80 % of men agree with the statement „men should have the same responsibility for the household as women.“ However, in 75 % of households, women do more chores.“ (Chramková et al., 2022, str. 345) Chrámková and others stated that the causal relations of a discrepancy between the opinions and the behaviour is hard to determine, posing a question if the distinction can be triggered by differences in income between men and women and traditional attitudes toward childcare, leaving women responsible for the unpaid domestic work, even after the intense parenting period is over.

The Gender Equality Index presented the imbalance between women and men in care provision. The division of roles appointed to men as breadwinners and women as carers is slowly dissolving since most working-age are employed. However, women more often do most of the unpaid work in the household (EIGE, 2021). The pandemic highlighted the higher burden of informal care on women and its impact on their work-life balance. Czechia obtained 57.3 points out of 100 on the Gender Equality Index.

The report presents „people caring for and educating their children or grandchildren, elderly or people with disabilities, every day“ in 33 % of women and 20 % of men. For couples with children, it is 70 % women and 48 % men, whereas 8 % women and 5 % men in childless couples. People doing cooking and household chores daily are 67 % women and 16 % men (EIGE, 2021). During the COVID-19 pandemic, mothers of children under 12 struggled to combine work and care responsibilities. This group of women reported more work-life conflicts than fathers of children of the same age and childless people (EIGE, 2021).

1.4.2. Cultural Approach

A significant impact of motherhood can be observed on women employees due to specific cultural and institutional pressures. The family policy led to strengthening some of the “new social risks” (Formánková et al., 2010), specifically negatively influencing the women employees in work-life balance, leaving them often with a double burden (Formánková et al., 2016), affecting equality in the labour market. A method through which this issue can be approached includes studying the cultural expectations and beliefs that involve the actions of both men and women play a role (Formánková et al., 2016). This perspective highlights the impact gender roles have on the division of household work and caregiving, which are all tied to cultural ideas about gender roles, including norms and values related to career and caregiving (Kremer, 2007). According to Kremer, relying only on social policies does not provide a change in women’s employment and points out the need to support the transition from the grassroots level

“Social policy bars do not hold women back in the cultural approach. If mothers do not work, it is because they do not want to: they want to care.“ (Kremer, 2007, str. 20) The cross-national study of social policy described that cheaper childcare services do not equal more working mothers. The decision of mothers whether to work or to stay on parental leave is not only a logical question of what is economically more beneficial (Kremer, 2007). The question of combining work and personal life is influenced by gender stereotypes (Formánková et al., 2016). Gendered moral rationalities influence everyday life decisions with structural and institutional conditions and shape appropriate patterns of female employment and welfare state policies (Duncan & Edwards, 1999).

The social policies regarding the family approach to gender norms through policy arrangements can maintain or alter the given gender norms. Parental and predominantly female employment possibilities are affected by the state support of families Pfau-Effinger, 2004 (Formánková et al., 2016).

The patterns in parental leave can be illustrated by the lack of nurseries and kindergartens and up to four years of paid parental allowance (Kuchařová, 2006). It can be attributed to the effects of the cultural norm of „full-time motherhood“ enrooted in the essentialist understanding of gender roles (Fellegi, Kočí, & Benešová, Work and Family Balance in Top Diplomacy: The Case of the Czech Republic, 2023), that prevails in Czechia (Formánková et al.; Zannela, 2017). “full-time motherhood” is supported by governmental policy (Formánková a Dobtoricoc, 2011). Such decisions can benefit low-income mothers due to the lack of financial access to day nurseries or childcare. However, it leads to an increase in problems with finding employment or future lower-income job (Bičáková & Kalíšková, 2015).

The full-time motherhood frame can be traced in Czechia in the 1960s when experts said ‘young children should be at home with their mother’. Such statements were accepted by economists and politicians and resonated well with overburdened mothers. The conservative belief about stereotypical and separate gender roles in the family supported such framing (Hašková & Dudová, 2017). During the communist regime between 1948 and 1989, when employment was mandatory, the tradition of a high percentage of employed women emerged. However, the idea of mothers having the "free choice" to not work for pay was reintroduced after 1989 as a response to the pre-1989 obligation to work (even though this obligation never applied to mothers in Czechoslovakia), together with the notion promoted by early childhood psychologist in Czechia that "young children should stay home with their mothers," the stance to stay at home with small children became common (Hašková & Dudová, 2017). Such development was supported by the withdrawal of state funding for day nurseries in 1990.

Women in Czechia bear the double burden of working and caring activities, resulting in the uneasy combination of family and career (Fellegi et al., 2023). Previously presented data about parental leave, care for children, and unpaid domestic work confirmed the gender gap and double burden that women have. Women carry such a load most of their lives, especially in households with younger children, which declines only after retirement (Zannela, 2017). Dr. Newman pointed out that in such cases, women in leadership roles experience a triple burden (Newman, 2011).

1.5. Theories related to gender discrimination of young physicians

1.5.1. Gender contract

The notion of a gender contract was introduced first as a theoretical concept. It examines the power dynamics regarding the work and household practices within a household and its possible impact on broader societal agreements centred around gender roles (Haandrikman et al., 2019). This concept provided functional optics for women's positions in Czechia and young female physicians.

The gender contract theory stems from the historical investigations of Yvonne Hirdman, studying how gender systems are categorised into male and female spheres (Haandrikman et al., 2019). Hirdman defined "gender contracts" as outcomes from negotiations between men and women on matters like labour, family, and power (Hirdman, 1993).

Hirdman posits that gender contracts exist across three levels of the gender system: metaphysical, institutional, and individual. The perception and anticipation of male-female relationships (metaphysical), institutionalised gender disparities and divisions of labour (institutional), and specific agreements between individual men and women (individual) all contribute to the framework of a gender contract. Unique gender contracts evolve through conflict, negotiation, and re-negotiation, with new conflicts and negotiations leading to changes over time (Forsberg, 2010). These shifts mirror changes in the three levels, thus unveiling how ongoing unequal labour divisions are shaped, internalised, and moulded within gender-based power structures. Tracking gender contracts can provide insights into local responses to policy changes and allow gradual progress.

Simon Duncan studied gender inequality within European regions, emphasising the localised gender contracts (Duncan, 1995). These studies explored variations in gender relations and began examining the regional and local cultural contexts contributing to gender inequality. It was noted that the nature, extent, origins, and impact of gender inequality vary significantly across different times and places. According to Duncan, gender contracts are "social agreements on what men and women are, what they think and expect, and what they do" (Duncan, 1995 p. 265).

While women are structurally subordinate, they remain active agents in constructing and maintaining gender contracts. Changing contracts showcase how negotiations are influenced by the interplay between different gender system levels (Haandrikman, Webster, & Duvancer, 2019). Depending on the context, women and men have dissimilar opportunities for altering or managing their positions and experiences. (Caretta M. A., 2015).

Challenges to gender contract theory include an overreliance on normativity and neglect of homosocial practices within contract production (Webster & Caretta, 2016). The notion was criticised for focusing on the binary gender system of heteronormative family structures (Haandrikman, Webster, & Duvancer, 2019).

Another criticism concerns the excessive emphasis on male dominance and negotiation of male privilege as the primary catalyst, which side-lines women's potential agency in contract creation. The readiness of gender contract theory to accommodate rapid social change is also questioned by (Caretta & Webster, 2016).

Though challenging theoretically and methodologically, gender contracts offer insight into gender inequality processes at regional or local levels. Gender contracts bridge the gap between individual choices and actions (gender contracts) and larger institutional and structural forces shaping outcomes. With spatial context (regions or countries), gender contract theory provides nuanced insights into socioeconomic factors influencing local policy responses (Haandrikman et al., 2019).

Simerská (2000), in her research about the work-life balance of young female physicians, defined a gender contract as a set of implicit and explicit rules governing gender relations, distributing differing work, values, responsibilities, and duties to women and men. These rules favour one gender over another across various life domains and are applied in everyday situations (European Commission, 1998). These contracts exist at the cultural superstructure level, encompassing society's norms and values, the institutional level within education, work, and other systems, and finally, within socialisation processes, particularly within families (Gender, 2000). Such an approach supports Gibson's (2018) defying the gender contract, which also encompasses power balance and resource access, which maintains a specific social order.

For instance, it defines roles within the marital system, designating women as family caregivers (Gibson et al., 2018).

These descriptions of gender contracts do not mention the negotiation process of gender roles and power; they refer to pre-set societal structures based on agreements set in past generations and structures. In this thesis, gender contract is used considering dissimilar opportunities women and men have for altering or managing their positions and experiences (Caretta, 2015). However, in the analysis, the idea behind the introduction of gender contract as a concept, „which examines how power negotiations over work and home practices, in a household, translate into a broader set of gendered societal 'contracts'" (Haandrikman, Webster, & Duvancer, 2019) and vice versa, meaning if broader negotiations over societal gender contracts translate into household.

1.5.2.Feminist theory

Feminist or gender theories focus on factors beyond the labour market that economists often consider fixed. A foundational idea in these theories is that women's disadvantaged position within the labour market is both a consequence of and a reflection of the patriarchal structure and the subordinate role of women in society and the family (Anker, 1997). Across all societies, responsibilities like household chores and childcare are typically assigned to women, while being the primary breadwinner is seen as a role for men. Even though these societal norms and perceptions do not always align with the experiences of many women, men, and families, they still significantly impact people's actions and contribute to gender-based discrimination against women. This division of responsibilities and the patriarchal framework of society play a significant role in explaining why women often possess less accumulated knowledge and skills than men before entering the labour market (Anker, 1997). This is evident in girls receiving less education than boys and being less likely to pursue fields of study, such as sciences and trades, that are more relevant to the labour market. Overall, there is a perception that women require fewer labour market-related skills. These same influences also affect why women tend to have less labour market experience, on average. Many women leave the workforce early, and others take temporary breaks due to these dynamics (Anker, 1997).

2. Methodology

2.1. Research approach

The research methodology is based on postmodern feminist epistemology, which is introduced. Further are introduced relevant notions, such as gender and intersectionality.

2.1.1. A deductive approach

At the beginning of this study was an assumption based on the personal experiences of young female physicians with discrimination based on gender and age shared with me. Due to the persisting gender inequality in Czechia, as was illustrated earlier based on data from the Gender Equality Index and other sources. The assumption led to developing a hypothesis to be proved or disproved.

1. Young female physicians experience gender-based discrimination.
2. The experiences affect their motivation to aspire to or to reach a higher position.

The assumption of discrimination is based on the general gender inequality in Czechia presented earlier and the existing data about discrimination of young female physicians, which are limited but support the initial theory. However the inf
The data obtained in this study - quantitative combined with qualitative data from the survey serve to test the hypothesis and confirm it or revise it (Bryman, 2016).

2.1.2. The postmodern feminist epistemology

Postmodern feminism epistemology proposes that instead of one essential truth, there are multiple subjective truths based on personal experiences, society, culture, and spoken and written words (Frost & Elichaoff, 2013). Postmodern feminism approaches knowledge as something created, unlike in traditional science. Postmodern feminist epistemology explores women's experiences and behaviour concerning the societal context (Leavy, 2007). However, postmodernism shifts focus away from hegemonic norms that perceive women as members of a group that deviates from the norm (Frost & Elichaoff, 2013).

Postmodernism focuses on everyone's experience, moving away from often arbitrary categories such as man and woman. It deconstructs categories rooted in culture, society, and class distinctions and shifts focus on individual experience within groups, resulting in questioning formed groups. Postmodernism challenges the essentialist approach to identity categories, such as women as fixed notions, highlighting the possible perpetuation of power interests (Frost & Elichaoff, 2013).

Leavy (2007) discussed the possible clash between postmodernism and feminism. Feminism has been pursuing to end women's oppression through identity politics, focusing on women's experiences. Essentialist categories like "women's experience" helped the feminist efforts. However, critics perceived that they can lead to reinforcing hegemony and dominant gender ideas (Leavy, 2007). Conversely, postmodernism seeks to deconstruct essentialist terms like women's experience.

Postmodern feminism aims to deconstruct gender norms, not reinforce them, by challenging the essentialism of feminist empiricism and standpoint epistemology (Leavy, 2007). Butler argued that power and discursive fields create the subject and gender identity (Butler, 2006). A unifying feminist approach to gender identity can be seen through the lens of societal power structures. This does not mean that personal experience of gender is less authentic or valid. The approach allows us to challenge and shift the dominant ideas about gender roles and expectations imposed by society, enabling us to question the ideas and terms through people perceive their gender (Leavy, 2007). Postmodern feminism challenges traditional notions and remains aligned with feminist goals. It encourages the deconstruction of gender norms.

Postmodernism led feminist researchers to reconsider experience as a category for knowledge building. Feminist focus on the absence of women 's experience in research led to exploring women's specific standpoint in a hierarchically structured society through the thoughts, feelings, and situations described by women (Leavy, 2007). Feminism and postmodernism both acknowledge the complexity of experience and the relevance of power and power relations. However, gender is not a universal category that can be empirically defined and measured. Leavy describes gender as a dichotomous and independent variable, criticising Butler (1993), who highlights the aspect of performance of gender, pointing to gender as a continuous variable. Gender identity, according to Butler (1993), is affected by the way society talks an (Butler,

Bodies That Matter: On the Discursive Limits of Sex, 1993)d portrays, in the case of femininity, as an idealised presence. Meaning that the idea of femininity is affected by society‘s ideas and standards (Butler, 1993)

Modernist focus on meta-narratives led to exclusive approaches and failure to consider differences (Hepburn, 1999). Lyotard (1984) supports the idea by referring to the fact that grand narratives often ignore different viewpoints and exclude ideas that do not fit them. Feminism and postmodernism highlight that these grand theories can leave out the voices of marginalised people because they do not necessarily reflect the power structures. Post-modernism points out the social construction of reality, exploring how some constructions can serve specific groups. (Layton, 1998). Postmodernism provides feminists with methodological space for challenging the metanarratives that sustain the oppression of women, minorities, and other vulnerable groups.

The postmodern feminist approach highlights the context and time and recognises the influences impacting differently shaped realities. It highlights the variations of women’s lives and identities, reflecting how they are perceived and influenced by themselves and others. This approach identifies and explores multiple intersecting characteristics such as gender, sexuality, race, and age (Leavy, 2007).

2.1.2.1. Gender

Gender is a term that refers to cultural construction around sex (Butler, 2006). Simone de Beauvoir in The Second Sex presents that „one is not born a woman, but, instead, becomes one“ (Beauvoir, 1973, str. 301), referring to the construction of gender based on expectations and gender stereotypes. Butler defines sex as an anatomical facility, and the attributes connected to it are affected by cultural meaning (Butler, 2006). Our understanding of what it means to be male or female is based on and shaped by culture and language. Butler described that gender is affected by sex so profoundly that it seems to be a fixed, natural fact, even though it is a result of cultural and linguistic influence (Butler, 2006). It leads to the assumption that only two genders (male and female) exist and are directly fixed by one’s biological sex. The notion of gender would then mirror the idea of sex. Therefore, gender can be used to sustain power relations, social norms, and structures (Butler, 2006).

The gender binary can falsely disconnect feminine and masculine, resulting in fixed ideas about gender (Wade & Marx Ferree, 2015). Wade (2015) describes the gender stereotype that women have small hands and, therefore, are more suitable for sewing; however, it is not noticed as a characteristic that could make one excellent surgeon. „How sewing and surgery are alike tends to escape our notice because they have been socially connected to femininity and masculinity, respectively, which we culturally expect to be opposites (Wade & Marx Ferree, 2015, str. 31). This is connected to the concept of gender binary classes that results in division everything into masculine and feminine categories.

Ramazanoglu (2002) describe different notions that are connected to gender. It can be approached as „(1) what people (and their bodies) are; (2) what people do; (3) what relationships and inequalities they make; (4) what meanings all these are given; (5) what social effects ideas of gender can produce.“ (Ramazanoglu & Holland, 2002, str. 4) The conceptualisation of interactions of gender with other aspects of identity and categories of people. The perspective of studying gender can, therefore, differ. This follows Ramazanoglu’s approach, which described that feminist knowledge of gender „include social investigation of gendered lives, experiences, relationships and inequalities “ (Ramazanoglu & Holland, 2002, str. 4).

This study predominantly investigates the hetero relations and binary gender categories of men and women, focusing on the division of care and household responsibilities among men and women. The study does not include data about homosexual couples and their functioning due to the visible impact of discrimination on women who carry a double burden. However, the study claims that women have specific positions due to the „full-motherhood“ expectation in Czech society. This can also affect homosexual couples in the expected length of parental leave and systemic limitations such as unavailable day-care for children under three years old. This systemic setting can cause a double burden among same-sex couples the same way as for hetero couples.

A binary approach to gender, which Butler (2006) criticises, does not mean that the categories are perceived as connected to biological sex or fixed in general (Leavy, 2007). Therefore, the societal and cultural background is presented earlier to set the scene in which people in Czechia exist and which shapes their identity. The social and cultural pressure to submit to gender contracts and gender norms is presented to show the limited space for individuals to explore what their gender means to them (Butler, 2006). Gender nonconforming individuals can experience more pressure or discrimination.

The study aims to explore the individual experiences, attitudes, and opinions simultaneously affecting and being affected by interpersonal interactions. The same applies to the institutional level, which is (Hill Collins & Bilge, 2016) more rigid to change and more likely to affect the individual and interpersonal levels. This approach serves to reflect the power relations. The experience of women can be, in many cases, similar, and it could lead to an essentialist understanding of the nature of women and men; however, connecting all three levels makes up a space for a critical approach. The category of gender is used in line with the flexibility of the concept concerning culture and personal experience. However, it reflects that most people fit one of the binary categories of gender.

2.1.2.2. Intersectionality

Intersectionality describes the interaction between systems of oppression, often relating to gender, race/ethnicity, and class. Intersectionality creates space for examining the interaction of multiple marginalisations to enlighten how power is related to specific categories and is excluded from others (Crenshaw K. , 1991). It describes a way of understanding and studying the complexity of the world and their experiences. This analytical tool can be applied differently to study various social issues (Hill Collins & Bilge, 2016).

Kimberlé Crenshaw introduced the concept to describe the marginalisation of African American women in antidiscrimination law and feminist antiracist theory (Crenshaw, 2013). The concept highlighted discrimination based on belonging to two oppressed groups. It enabled them to highlight their specific problems, perspectives, identities (Weldon, 2008). In the context of social inequality, people’s lives are shaped by several social divisions such as race, gender and class. The intersecting criteria can be combined since people are part of different social groups (Weldon, 2008).

Intersectionality does not apply only to marginalised groups. Intersectionality acknowledges a social organisation that impacts all lives, gender structures impact all groups, and everyone has race/ethnical belonging. Intersectionality can identify commonalities and support solidarity among oppressed groups (Crenshaw, 2013).

Intersectionality is a critical concept highlighting limitations in understanding relations within the social structures and their complexity. Intersectionality, therefore, does not mean dual systems theory, which is based on the idea that patriarchy and capitalism are two separate

systems (Weldon, 2008). „The concept of intersectionality offers a way of articulating this critique concerning intersecting social structures more generally, not just the interaction of race and class.“ (Weldon, 2008, p. 197) Intersectionality critics also layered perceptions of oppression, pointing out the limitation of concepts of double burden. Intersectionality approaches oppressed groups, highlighting their more disadvantaged position and acknowledging the privilege of certain groups (Weldon, 2008). On the other hand, everybody is part of several social groups, meaning they can be intersectional marginalised, intersectional privileged, or both (Taefi, 2011).

The intersecting axis in this study is gender and age in the workforce. Choroszewicz (2019) highlighted that researchers often neglected age as an intersecting category due to differences from other aspects of inequality (Acker, 2006 in Choroszewicz & Adams, 2019). On the other hand, Choroszewicz stated that gender disadvantages are interconnected with age, generation, and life course, for example, due to different trajectories of entry into the labour market (Choroszewicz & Adams, 2019). Starting a full-time job can be a struggle due to the new physical, mental and emotional load. This can intersect with gender discrimination, forming specific experiences of discrimination among young female professionals. To support the relevance of applying intersectionality, only some findings are presented. Young professionals can also be subjected to stereotypes about low competence, unreliable, uncommitted, and disrespectful (Laird, Harvey, & Lancaster, 2015).

Research showed that young professionals, among men, had more positive experiences and had access to more opportunities (Coley, 2017 in Laird, Harvey, & Lancaster, 2015). Male-dominated professions can lead to hostile work environments, more sexist comments, and gender-based aggression from male co-workers. Often, women leave such fields to avoid everyday discrimination.

Several aspects support gender bias toward female employees. Women’s activity in the workforce is affected (or expected to be affected) by periods of economic inactivity due to child rearing and other commitments connected to the care of children and responsibility for household chores (Duncan & Loretto, 2004).

2.2. Mixed-methods research

Feminist researchers are associated with qualitative research methods, new strategies and exploring new qualitative methods. Qualitative research is grounded in „the experience and meanings individuals attribute to the world around them“ (Leavy, 2007). On the other hand, quantitative research methods are often deductive, predicated and therefore hypothesis driven (Bryman, 2016). This approach is rooted in paradigms such as positivist and postpositivist, seeking objective knowledge about the society (Leavy, 2007). The mixed method combines qualitative and quantitative research in a single project (Bryman, 2016).

Researchers choose mixed methods for reasons such as triangulation, when the study of data is crosschecked with other research methods (Bryman, 2016). Feminist researchers add layers, including double consciousness, interest in subjugated knowledge and oppressed voices, to empower the researcher and participants (Spalter-Roth & Hartman, 1999 in Leavy, 2007).

Quantitative methods are often perceived as limited; perhaps data obtained through surveys do not allow the researcher to explore sure sides of the studied issue (Leavy, 2007). Mixed methods combine quantitative and qualitative data to answer questions.Mixed methods can refer to combining several possible combinations - only quantitative or only qualitative methods or a

combination of both. Morgan (2014) defined categories of mixed methods based on the priority of used methods.

The design used in this study is according to these categories QUANT, referring to the qualitative method as the primary one. This type of mixed method is often used in studies which need to be clarified or elaborated on the results from quantitative data (Morgan, 2014).

This method seems suitable for the study's goals and answering the hypothesis. The quantitative method can support the presumption that young female physicians experience gender-based violence and the second hypothesis that the experience affects their motivation/aspiration to reach higher positions. The qualitative data obtained through the questionnaire support findings relating to the second hypothesis and give insight into the experiences. The study uses a quantitative method in assessing testimonies about such experiences, not only from women but with a focus on them. The qualitative data obtained through the surveys provide limited depth.

In feminist research, qualitative data is often used (Frost & Elichaoff, 2013). However, using qualitative data is valuable. The knowledge in social science has been built on quantitative research methods. These data, perceived as more objective, can help mainstream specific topics. Quantitative can promote social change by reaching the non-feminist public. These methods can be compared to measurable progress in society (Leavy, 2007).

2.2.1. Questionnaire

A questionnaire is a tool for collecting required primary quantitative data from respondents in a standardised way (Roopa & Rani, 2012). They can be used, for example, as part of structured interviews or self-completion questionnaire (Taherdoost, 2016). In this study, a self-completion questionnaire was distributed online. This approach is an effective and accessible way of collecting quantitative data across broadly spread participants, mainly while it is disseminated online (Taherdoost, 2016) and among large groups of online users (Bryman, 2016)

Questionnaires usually combine questions focused on facts, people's attitudes, knowledge and beliefs (Duffett et al., 2012, p. 441.). The wording of questions must be considered to maximise reliability (Somekh & Levis, 2011). The self-completion questionnaire should use simple and specific language, cover all possible response contingencies, and include mutually exclusive response options (Roopa & Rani, 2012). The survey was tested on a few respondents from the target group is relevant. The pilot study verifies that the questions and possible answer categories are clear (Taherdoost, 2016).

Purposive sampling

Sample means a segment of the population that is chosen for investigation. The chosen sample can cause the results to be biased or have (Kayam & Hirsch, 2012) low response rate (Duffer, a další, 2012)

This study applied purposive sampling, which aims to reach a sample relevant to the research through strategies (Bryman, 2016). This study focuses explicitly on surveying physicians within the age range (25 to 35 years old). Purposive sampling, unlike convenience sampling, focuses on the goal of the study instead of the researcher's goal (Bryman, 2016).

Purposive sampling includes choosing channels for sharing the questionnaire, which impacts the reached audience (Bryman, 2016). By choosing concrete channels on social media that target young physicians for sharing the questionnaire and by sharing the questionnaire in the Facebook group for young physicians, the sampling was affected to fit the goal of this study.

The sampling impacts the generalizability of the study. The results may partially represent all physicians within that age range, but the data still provide insight (Bryman, 2016).

2.2.2. Data collection

The survey for this study was created using Google Forms. It is one of Google Document tools, free of charge, and easily operated. The survey included the explanation of the study, the target group – physicians between 25 years old and 35 years old, and the survey length to ensure that potential respondents know how long it will take them (6-8 minutes). Even though the hypothesis of this study focuses on the gender discrimination women physicians experience and the impact on their aspirations, the questionnaire was not limited to people based on their gender. The approach was chosen to give insight into the experiences of all groups which might be excluded in studies on gender discrimination. The second reason was to obtain data from male peers to compare whether they also experience discrimination and recognise discrimination that targets their female peers. The idea was to study their awareness of their privileges and marginalisation of other groups.

The anonymity of the study was presented and also, in line with GDPR, stated that „by completing the questionnaire, you consent to processing provided data". The introduction also presented information about the researcher and the institutional belonging to ensure the legitimacy of the questionnaire, which is fair and supports a higher response rate (Brenner, 2021).

The questionnaire used several types of questions. The first type was closed-ended questions, meaning respondents are limited to a fixed set of responses (Roopa & Rani, 2012). The yes/no questions are used a few times. Respondents are often given multiple choices to cover all possible contingencies of a response and include mutually exclusive response options (Roopa & Rani, 2012). Further types of closed-ended questions used in the questionnaire were scaled questions, meaning that the „responses are graded on a continuum" (Roopa & Rani, 2012).

The questionnaire also posed open-ended questions, leaving the respondents to answer in their own words without suggested categories. These questions were utterly unstructured (Roopa & Rani, 2012). Open questions were used only twice to find out about an experience that respondents answered that they had/seen.

1. Have you experienced unwanted touches with a sexual undertone without your consent? For those who said yes, a new set of questions opened:

If this experience affected you, please write down how.

2. *Have you experienced or witnessed any form of gender discrimination in your workplace?*

Please write down your experience.

The survey first collects general information about the respondent, such as age, nationality, belonging to ethnical minorities and gender. The approach of this study to gender is that it is not a fixed category. However, they are perpetuated by various processes at different levels.

„The cultures and practices of medicine are interrelated with the social contexts in which health care is delivered. The models of healthcare are of the same importance. They define the conditions of access and work that vary over time of male and female physicians and their

interactions with patients. “ (Spina & Vicarelli, 2015, str. 121). Therefore, the questionnaire is divided into individual, interpersonal, and institutional sections. Within individual category were posed questions regarding one perception of their possibilities and aspirations regarding their gender and gender roles, such as, „Does your gender makes it harder to develop professionally?” and „ Did the speciality training process affect when you plan or have planned to have children.“. The most relevant question about the hypothesis is, „Do you plan to pursue a leadership position in the future?”. It refers to the second hypothesis, whether the experiences with discrimination affect one's aspirations for a leadership position.

In the interpersonal section, questions are focused on what respondents experience from their colleagues, patients and leadership regarding gender-different forms of discrimination, such as unwanted sexual remarks and unconsented touches with a sexual undertone. One question was related to discrimination related to having children: „Have you been asked in a job interview if or when you plan to have children?“.

Questions in this section focus on bias, such as respect from co-workers and valuing their professional opinions from colleagues and leadership. Attention is also given to the possibilities to develop professionally. „ Do you feel that you have the same opportunities to professionally develop in your field as your peers of different genders?“ These questions can answer the first hypothesis, proving or disproving that gender discrimination of young female physicians occurs. This section, combined with the question of whether the respondent plans to pursue leadership positions, sets the ground for answering the second hypothesis. The intersection between experienced discrimination and bias with the respondent’s aspiration provides needed data to support the correlation between the two aspects. However, it may be limited in proving the causality.

The last section of the questionnaire is focused on the institutional level. The questions are related to institutional tools that could dismantle discrimination and reflect on the work environment's stance towards this issue and the respondents' reflection on the institutional conditions. Some of the questions were – „ Do you think that there is a need to provide better conditions for returning to work from parental leave in the healthcare sector?“, „ Do you think that gender discrimination affects the employment opportunities of female doctors?“, „Does your workplace have support systems or tools to address gender discrimination and sexual harassment?“. This section does not directly relate to the hypothesis; however, it presents data about the setting in the institution, which impacts the occurrence of gender discrimination. For technical problems, this section includes one question meant for the interpersonal section, „Have you experienced or witnessed any form of gender discrimination in my workspace?“. This question directly approaches the issue; however, it does not provide suitable data supporting the second hypothesis since it extends to witnessing discrimination. However, it shows the prevalence of gender discrimination in the Czech healthcare system towards young physicians.

The process of making the questionnaire was affected by consideration of not using the word gender. Czech language, in which this survey was made and the data were collected, does not have a translation for “gender”. The term gender is misunderstood among the public since it is misused or abused by the anti-gender movement and certain politicians (Fellegi, 2019).

In the process of making the survey, I was hesitant about whether to use “gender”, which is the right option. However, it could mean some people will not complete the survey once they see it. The second issue was that some sentences or phrases gender did not fit. However, substituting gender with “sex” would limit the gained knowledge about gender-based discrimination. The survey uses, therefore, “gender”. It was challenging to find formulations that fit “gender” and

be evident to respondents. Before sharing the survey, I piloted the questionnaire on two physicians to ensure understandability (Taherdoost, 2016). I received feedback from a physician, highlighting that many people, especially men, might be discouraged by the term "gender". I chose to explain briefly what "gender" is in the first question. For this, the Czech Statistical Office (Český statistický úřad) can be perceived as a neutral and well-known source. However, no gender-nonconforming person completed the questionnaire.

The challenge with online data collection is to verify if data pollution occurred by trolls who, on purpose, could falsely fill in questionnaire (Kayam & Hirsch, 2012). Therefore, the obtained data were studied to detect possible trolls that chose to sabotage the survey with their answers, which will be further described in a section focused on data

2.2.2.1. Distribution

This questionnaire was disseminated through social media networks, specifically Facebook and Instagram. As interpersonal communication expands on social media networks, researchers acknowledge it as a tool to reach participants in social research (Kayam & Hirsch, 2012). Social media networks enable one to reach a high amount of people in a short period. It also includes respondents, considering their limited time capacity (Bryman, 2016). Respondents choose when they have time to answer the questionnaire. For physicians, it is a reasonable approach; for example, some respondents filled out the form at night.

The shared content was adjusted for the target group (Couper, Traugott, & Lamias, 2001) by preparing memes that humorously invited young physicians to engage with the questionnaire. Online space supports voluntarity; participants have less pressure to please the researcher (Kayam & Hirsch, 2012).

The possible disadvantage arises in the question of the representativeness of the data. Price and electronics are more accessible. However, it must be considered that some people do not have internet or are not on social media networks (Kayam & Hirsch, 2012); for the target group, which is physicians between 25 years old and 35 years old, most of them should be able to access the survey.

I contacted five Instagram accounts to share content for physicians to reach the target audience – physicians between 25 and 35 years old. These accounts shared it in „story, " meaning the content disappeared after 24 hours. The accounts were not focused on gender discrimination and, therefore, enabled the reach of the questionnaire to a broad group of physicians. Several accounts on Instagram that focus on social equality were also approached and shared the survey. However, the group reached a clear stance towards gender discrimination. After collecting over 150 answers, I realised that online surveys are easily spread; however, they can be filled by non-physician people who do not fall under the studied age group or online trolls.

Therefore, I decided to maximally limit the access of non-target audiences to the questionnaire as much as possible. Via email, I contacted student clubs and alum clubs from the medicine faculties in the Czech Republic, asking them to share the survey. However, they did not share it.

Last, I shared the survey in a private group on Facebook called "Young Physicians" (Mladí lékaři) with 12,000 members. To join this group, a person had to fill out a short questionnaire that focused on ensuring that the person applying was, in fact, a physician or a student of medicine. I stated that I am not a physician. However, I wanted to share a questionnaire, and the administrators admitted me to the group. However, later on, they cancelled my membership in the group. This supports the idea that members of this group are mostly, if not only,

physicians and students of medicine. After sharing the questionnaire, 216 people answered the questionnaire.

2.3. Generalizability

The collected quantitative data present a relevant sample of young physicians that could represent to some extent the experiences of female physicians between 25 years and 35 years. Unfortunately, only

45 male physicians completed the questionnaire, so these data could not be generalized.

The purposive sampling presented a suitable method to collect data from such a specific group. t was acknowledged, as I influenced where the questionnaire was distributed predominantly among the target group.

To assess the generalizability of these data generally for young physicians I would have to secure more male physicians who would respond to the questionnaire. Helpful could be avoiding the word gender, which in Czechia has negative connotations are draw attention of the issue of discrimination, however, that would not fulfil the approach I have chosen in this study. I could try to reach out to male physicians either personally or by email, however obtaining email addresses is highly complicated, as I found out.

The findings could provide useful insight into the functioning of the healthcare system to the public. And support current efforts of associations of young physicians to secure better conditions. It could provide them with insight into gender discrimination, so it would be considered in their approach to young physicians' conditions.

However, from the postmodern feminist epistemology point, the assessed data are more subjective and explore some experiences. At the same time include my personal biases which are impacted by my background as a middle-class white woman in Czech Republic.

2.4. Reliability

The quantitative data alone are reliable as the collection and data assessment occur transparently. Distributing the questionnaire over some period through the same channels would enable obtaining resembling data.

The data analysis includes subjectivity in setting quantitative data into the societal and cultural context related to my experiences. The chosen postmodern feminist epistemology acknowledges that objective truth does not exist; qualitative data assessment could be approached differently by a person with a different background, who would set them in a societal context differently.

2.5. Validity

The questionnaire was prepared to measure if young female physicians experience gender-based discrimination. The questionnaire directly asked at the end whether respondents witnessed/experienced gender discrimination. However, due to different perceptions and understanding of what gender discrimination is and what counts as discriminatory behaviour, further questions were asked related to gender discrimination, not using the term, such as given

opportunities for sexual harassment. These confirmed the first hypothesis that young female physicians experience gender-based discrimination.

The concept of the effect of gender discrimination on the motivation to aspire or to reach higher positions. The low motivation of young female physicians was shown in the results and compared to data about male peers. Gender discrimination was proven, and the extent can point to the negative impact on young female physicians. The correlation between gender discrimination and aspiration was somewhat proven; however, the quantitative data cannot prove the causality between discrimination resulting in motivation.

Content validity focuses on whether the questionnaire conforms to existing ideas or hypotheses concerning existing concepts (Roopa & Rani, 2012). By these merits, the questionnaire covers different forms of gender discrimination reflected in research.

2.6. Limitations of the study

The study focused on the discrimination of young female physicians; the questionnaire was open to anybody. However, only 45 young male physicians completed it. This study could be extended to physicians 35+ who may perceive and experience gender discrimination differently. Generally, more answers from male physicians would provide insight into the awareness of their privileges and stances toward gender discrimination.

For this study, purposive sampling was used to get the questionnaire to ensure that the target group answered the questionnaire. In my approach, I would change the strategy of sharing the questionnaire and not sharing it on social media, even though the target audience was predominantly young physicians. Over 200 respondents would still complete the questionnaires after one sharing. So, posting it twice in the group would help reach the same result, and the target group would be less likely to complete the questionnaire.

The process of choosing the right method was challenging, I was torn between providing generalizable data to prove gender discrimination and perhaps open discussion in the society, providing the data to Mladí lékaři (Young physicians) and Sekce mladých lékařů, who try to impact positive change.Therefore at the end the mixed methods where chosen

2.7. Ethically important moments

Four main areas were considered about possible ethical issues: whether there is harm to participants, whether there is a lack of informed consent, whether there is an invasion of privacy. (Bryman, 2016)

Regarding harm, I ensured the privacy of the participants (Roopa & Rani, 2012) since they answered personal questions regarding possibly uncomfortable and even traumatising experiences regarding discrimination and sexual harassment. The work conditions were discussed, and not securing anonymity and confidentiality could jeopardise one's employment or conditions at work.

Regarding consent, the respondents were informed that by submitting the form with a questionnaire, they consent to process provided data: „By completing the questionnaire, you consent to their (data) processing. " I did not want to provide my contact because gender discrimination is sensitive in Czechia, and I wanted to avoid spam emails or aggressive messages. However, the topic is personal to the respondents, so I wanted to allow them to

connect with me if they are interested. Therefore, at the end of the questionnaire, I posed the open question:

Several respondents wrote their e-mail addresses. They consented that I could use their data by sending the questionnaire, which was stated in the introduction.

3. Analysis

In this section are firstly presented obtained data. The qualitative data show the demographic that responded to the questionnaire. Further information on answers in the questionnaire's individual, interpersonal and institutional sections is presented.

Later, qualitative data related to two questions on the impact of sexual harassment and specific experiences with discrimination are presented.

Further follows the analysis itself.

3.2. Data

3.2.1. Quantitative data from the survey

Overall, 356 people completed the questionnaire. However, the data were evaluated to ensure the respondents were part of the target group for studying gender discrimination against young physicians in Czechia. Seventeen respondents worked abroad and were excluded from the questionnaire. And two respondents were identified as an online troll due to problematic answers. Altogether, data from 337 questionnaires were assessed as fulfilling the criteria of the studied group.

Demographics of the respondents

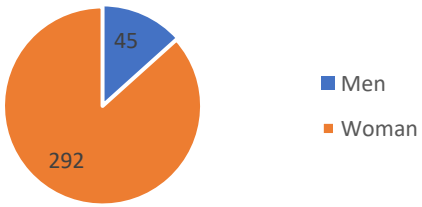

Chart n. 1: Respondents by gender

Overall, 337 respondents completed the questionnaire; 292 (86%) were women, 45 (13 %) were men.

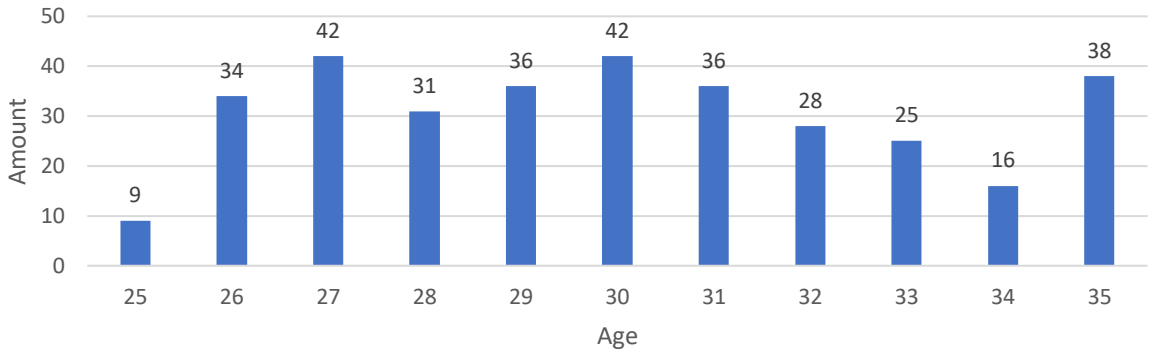

Chart n. 2: Age distribution

Most respondents were 27 and 30 years old.

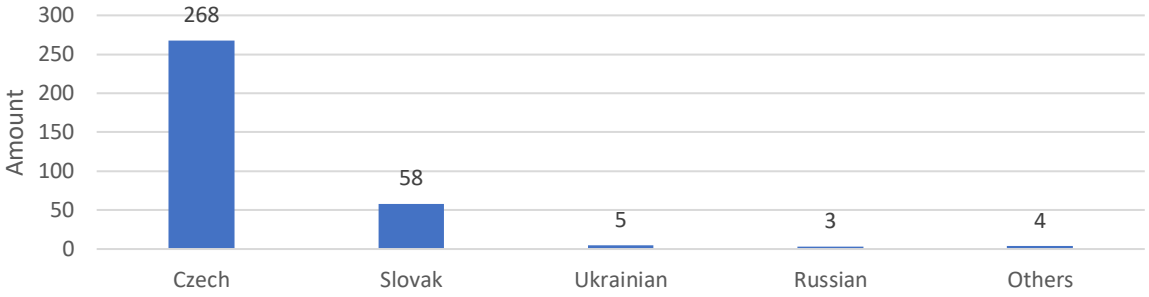

Chart n. 3: Nationality of respondents

The respondents were 79 % Czech nationality (267), Slovaks 17 % (58), Ukrainians 1.5 % (5), Russians 0.9 % (3), one respondent was Hungarian, 1 was Cyprus, and 1 was Chinese.

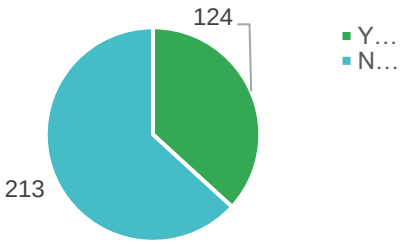

Chart n. 4: Do you have a child?

63 % of respondents (213) do not have, and 37 % of respondents have child/children (124).

Finished examination after graduation

As mentioned earlier, physicians, after graduation, must fulfil appropriate examinations for their medical field. The first exam is usually 30 months after graduation, and the specialisation examination depends on the chosen field from 3 to 6 years after graduation. 47 % of respondents (158) finished neither of the exams, 31 % of respondents (108) completed the first exam, and 21 % of respondents (72) finished the specialisation examination.

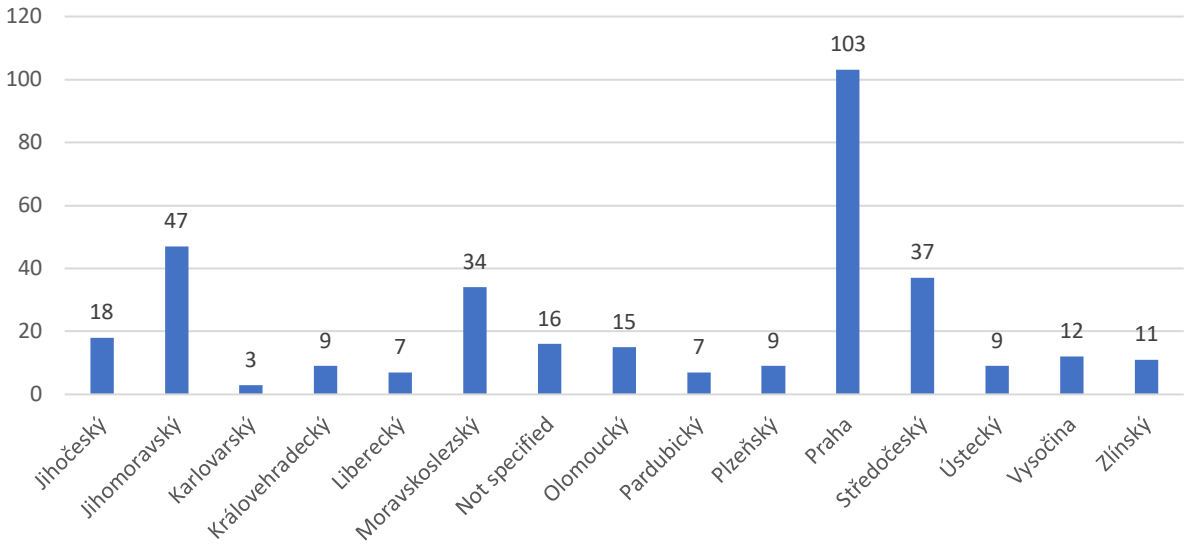

Chart n. 5: Regions of respondents

Most respondents work in Praha region 103. Then, work in the Jihomoravský region with 47 respondents, Středočeský with 37, and Moravskoslezský with 35.

Individual level

The first section of the questionnaire focuses on the individual mindset of the respondent and their perception of their possibilities and aspirations. The answers were divided into continuous scales from yes, rather yes, I do not know, to rather no, and no. The answers were united into two categories: yes and no.

Table n. 1: Questions on Individual level

Individual level *(% of respondents who answered „yes“, „rather yes“)*	*W (%)*	*M (%)*
Q1: Specialty training process affected when I plan or have planned to have children.	64,95	28,90
Q2: I am satisfied with my current position.	72,16	80,00
Q3: I plan to pursue a leadership position in the future.	28,08	44,44
Q4: There are innate differences between men and women regarding their ability to practice medicine.	31,45	53,33
Q5: The decision about my specialisation was impacted by my gender,	23,63	6,67
Q6: If I didn't have a family, my career options be better.	62,11	20,00
Q7: I am managing a work-life balance.	50,52	60,00
Q8: My previous work experience affected me negatively; how do I perceive the possibility of further professional development?	45,33	40,00

Q9: My gender makes it harder to develop professionally.	61,30	4,44
Q10: My gender affected my decision about my specialization.	23,63	6,67

Table n. 2: Q11 Based on what did you choose your specialization?

Based on what did you choose your specialisation? (number of respondents who chose given option)	*W (%)*	*M (%)*
financial asseessment	40	8
interest in the field	263	40
none of the options	12	4
possibility to combine with family care	94	7

This question included choosing more options; therefore, the presented data shows how many respondents chose the given answer.

Interpersonal level

This section focuses on the experiences with of physicians on with their colleagues, peers, and leadership.

Table n. 3: Questions on Interpersonal level

Interpersonal level (% of respondents who answered „yes“, „rather yes“)	*W (%)*	*M (%)*
Q12: I feel that my colleagues are more likely to value the views of employees of a certain gender.	48,45	20
Q13: I feel that my superiors are more likely to value the opinions of employees of a certain gender?	46,75	37,77
Q14: I think that my gender affects the level of respect I receive in the workplace.	70,79	48,89
Q15: (From those who answered yes and rather yes) I get less respect that people of different genders.	97,04	4,55
Q16: I feel that I am given less responsibility than my peers of a different gender	21,65	6,66
Q17: I feel that I was given the same opportunities to develop in my field as my peers of a different gender.	47,08	80

Q18: (From those who answered no and somewhat no) I was given fewer opportunities that my peers of a different gender	98	44,44
Q19: I have been asked in a job interview if or when I plan to have children	47,26	11,11
Q20: I have experienced unwanted sexual comments about myself in the workplace.	58,41	26,67
Q21: I have witnessed unwanted sexual remarks made to another person in the workplace.	64,94	62,22
Q22: I encounter comments at workspace that degrade a particular group based on gender.	63,91	44,44
Q23: I have experienced unwanted touching with sexual undertone at work without my consent.	22,76	20
Q24: I personally experienced or witnessed any form of gender discrimination in my workspace	68,28	42,22
Q25: Somebody told me that I should not pursue a particular specialty because of my gender.	74,63	29,55

AD Q12: The colleagues value more opinions from colleagues of certain gender: 84.8 % answered men, 10.9 % other and 4 % women.
AD Q13: The superiors value more opinions from colleagues of certain gender: 85 % answered men, 11 % other, 3.8 % women.
AD Q22: 2 % of respondents answered that degrading comments were about men, 6.5 % about other genders and 65.9 % about women.

Table n. 4: AD Q23 (W67, M=9))

How did you handle the situation? (Multiple choice)	*W*	*M*
I talked about it with my colleagues.	35	1
I talked with superiors.	5	0
I did not do anything.	53	5
I did not mind.	5	2
I left the workplace.	10	0
I objected.	40	4
I did not do anything because I knew nothing will change.	26	2

AD Q25:

Table n. 5: Has anyone ever told you that you shouldn't pursue a particular specialty because of your gender?

(Multiple choice)	*W*	*M*
At the interview	2	0
A close person	68	5
Colleagues	71	7
A patient	50	4
A senior doctor	71	4
A lecturer at university	209	12

This question included choosing more options and therefore the presented data show how many respondents chose given answer.

Institutional level

This section focus on the assessments of the institution for dealing with gender based discrimination, sexual harassment and also if it provides support.

Table n. 6: Questions on Institutional level

Institutional level *(% of respondents who answered „yes“, „rather yes“)*	*W (%)*	*M (%)*
Q26: In my opinion, there is a need to provide better conditions for returning to work from parental leave in the healthcare sector.	94,48	75,56
Q27: Does my workplace have a playgroup/nursery?	45,54	64,44
Q28: I think that gender discrimination affects the opportunities of female physicians at work.	92,76	60
Q29: I talk about gender discrimination issues in my workspace without problem.	23,1	37,27
Q30: There are support systems or tools in my workplace to address gender discrimination and sexual harassment.	5,86	4,44
Q31: I personally experienced or witnessed any form of gender discrimination in my workspace	68,28	42,22

Table n. 7: Are there any particular areas in which you think gender discrimination occurs?

Are there any particular areas in which you think gender discrimination occurs?	*W*	*M*
Admission to employment	248	30
Discrimination exists only at certain workplaces.	0	1
I do not think there is gender discrimination	6	6
Pregnancy / parental leave and return to work	5	0
Professional development	180	18
Respect	201	19
Sexual harassment	127	15
Wage	163	2
Trust from patients	2	0

The question allowed multiple choices and therefore the table above shows how many respondents chose certain answers.

2.7.1. Qualitative data from survey

This section presents qualitative data from the questionnaire regarding the personal experience with gender discrimination and the affect the experience with sexual harassment had on a person.

Overall, 110 respondents wrote about their personal or witnessed experiences with gender discrimination. The primary data for this study are quantitative. Therefore, some of the testimonies that are presented in this section to illustrate the most common areas in which gender discrimination occurs.

After the assessment of the testimonies, six theme groups were prepared. The data were then divided into the following sections 1. Professional opportunities, 2. Inappropriate comments /Sexual harassment, 3. Discrimination due to (possible) parenthood, 4. Value (wages, opinions), 5. Demeaning comments about minorities (Table n. 9, Table n.10, Table n. 11, Table n. 12, for the tables in Apendix A). These five categories cover the recurring themes mentioned in the testimonies, however the themes intersect, most often in category 1. Professional opportunities,

which include generally the accessibility to develop professionally, 3. Discrimination due to (possible) parenthood.

1. Professional opportunities

R40: Rejection of consultations, rejection of cooperation

R49: For example, the preparation of the educational events (man are compensated, young female physicians not because they will leave for maternity leave), leadership positions are automatically assinded based on gender.

R170: My first supervisor got rid of me after a trial period because he had men for the position

R67: Women left to less prestigious part of the field, reminders that opportunities come just because I am a woman. Orthopedics is specific in this, but in other fields, I do not see room for reducing gender discrimination until systemic support of maternity.

R243: 1. The male doctor without specialization exam supervised the female doctor with the attestation.

R83: - I have been assigned some unpleasant work because I am a woman (and that it is a job for "gentle female hands" that no man is suitable for).
- We (women) have told at the internships that we cannot be good obstetricians, for example, because "this is not a job for a woman because it requires thinking, quickly decision and strength, and woman is not capable of that"
2. Male doctors have a higher basic salary and evaluation than female doctors, despite doing the same work.3. Doctors always have priority over female doctors when they want to go to a course, internship or conference.

R188: Priority for even less capable male colleagues in professional growth just because they are men and I will go to maternity leave. A warning that female doctors who feel they do not want to do night shifts because of children should consider if they should continue working in the hospital.

R280: At the interview, I was told that they prefer men get more responsibility at the intensive care

R75: Senior doctor (female) repeatedly prefer male candidates. When (male colleagues) they show the same level of knowledge as their female peers in the same period of education, it is recommended that female physicians to give more professional attention to their male colleagues and not to bully him. Harder possibilities for female colleagues to return from maternal leave (parental), unwillingness to reduce the workings hours and unwillingness to support earlier return to profession sooner than after 3 years, even though she (senior doctor) returned to work for part-time soon after having a child. On top of that her statement: "Girls, you are so skilled, a shame that none of you is men".

R298: Unfortunately, in the Czech Republic, for many workplaces, the question of gender is a question of life and the death of the workforce. If, for example, most working physicians are women, they often stay at home with a sick child (they do not solve it at home and stay with them), and many other female and female colleagues must cover for them. Unfortunately, it is too common. Czech healthcare is based on overtime, and the loss of every physician can be a problem.

2. Sexual harassment

R79: „Inappropriate remarks on my (female) colleagues and me about potential pregnancy, "jokes" like let's dilute their contraception pills into the water. “

R228:A month after graduation, I was the only one to get married, so I was constantly asked if I was pregnant.“

R137: My older colleague came to the radiology assistant and put his head between her breasts and shook his head between the breasts.

R224: Women without specialization examination are victims of older male senior physicians and are afraid to object.

3. Discrimination due to parenthood

R188: „A warning that female doctors who feel they do not want to do night shifts because of children should consider if they should continue working in the hospital.

R14: I was told that I would not be accepted for the internship because ‘it does not make sense since I will go on maternity leave.

R227: A female colleague told the former head physician she was expecting a child. After this announcement, the head physician wanted to take her bonus based on personal evaluation, but the colleague refused to sign the new salary assessment.

R333: Repeated attacks on colleagues for their pregnancy.

R190: Firing my female colleague at the clinic and inpatient care on the same day as she announced that she was pregnant. “

R58: „3 years married female colleague announced that she is in the 6th week of pregnancy and that she would go on maternity in 7 months, announced the head physician who subsequently scolded her bad way ‘how she did not let her know earlier, why did she think that she will not work nightshifts, why did she return to workplace when she got pregnant after a year in this position.

R300:„Negative reactions (about pregnancy) and evoking a sense of guilt for leaving the maternity leave, leaving the work team and that someone else will have to work for them.

4. Value (wages, opinions)

R35: The same idea said by men and women.“

R328: One of the older colleagues has a habit of unnecessarily digging into the diagnostic conclusion of a neurologist's female colleague in a way that crosses the line because he mentions that the reason why he does not trust them is because they are women.

R83: - I have been assigned some unpleasant work because I am a woman (and that it is a job for "gentle female hands" that no man is suitable for). R83: - I have been assigned some unpleasant work because I am a woman (and that it is a job for "gentle female hands" that no man is suitable for).

We (women) have told at the internships that we cannot be good obstetricians, for example, because "this is not a job for a woman because it requires thinking, quickly decision and strength, and woman is not capable of that"

4. Demeaning comments about minorities

R67:Remarks from some colleagues (again mostly lower staff) to nonbinary people, transgender issues, homosexuals, refugees, etc. (expressions of the type "they are not people", "it does not exist", etc.) - I absolutely do not want to discuss it because I have no ambition to change their views and I do not have time to waste time with them, but I perceive it very negatively.

R214: I have witnessed the humiliation of gays. Although a colleague is obviously clever, he is simply gay and thus cut a branch under him.

R193: Inappropriate jokes about homosexuals and transgender people, and minorities (Roma people)

3.3. Analysis

The obtained data show the existence of gender-based discrimination against women. Overall data from 337 respondents was assessed; women comprised 86 % of respondents, and 13 % were men (Chart n.1). The gap among the respondents can point to these groups' motivation levels. The questionnaire respondents indicate high motivation to share their views due to experienced discrimination or disagreement with possible gender discrimination. As specific answers indicated, 3.5 % of respondents stated, "I do not think there is gender discrimination ".

The negative impact of gender discrimination on employment was recognised by 92.76 % of female respondents and 60 % of male respondents (Table n. 6). Young physicians experienced or witnessed gender discrimination 68.28 % of women and 42.% % of men (Table n. 3), confirming the existence of gender-based discrimination among young female physicians, supporting the hypothesis „**Young female physicians experience gender-based discrimination. "**

Firstly, the **individual level** showed that women perceive to a certain extent that they are affected by their gender. One aspect impacting the position of women is based on gender stereotypes; 31.45% of women and 53.33% of men believe that innate differences between men and women affect their ability to practice medicine entirely or to some extent (Table n. 1). These findings set the scene about the perception of capabilities to practice the physician profession linked to a person's gender. This perception is rooted in the fixed perception of gender as interchangeable with sex, which Butler (2006) which are results of cultural and linguistic influence. From what can be drawn, the prevalence of fixed gender roles is common and rooted in stereotypes based on one's biological attributes that support the perpetuation of discrimination.

The second hypothesis focuses on the effect of gender discrimination on female physicians' motivation to aspire or reach higher positions. 28 % of women shared interest in pursuing leadership positions in future, compared to 44.44 % of men. It shows a lower aspiration of young female physicians. The professional development at this age is connected to possible specific expectations on women having children; the average age for Czech women to have their first child is at 28,8 years (ČSÚ, 2022). The demanding process of graduation training and obtaining the first examination (around 30 months after graduation) and examination in specialisation (three to six years after graduation) affected 64.95 % of women in planning / or having children and only 28.9 % of men.

This is connected to predominantly women's capacity to have a child and the expectation that they will have one. However, it is interconnected with the reality of parental leave, which is 98.2 % (MPSV, 2022)taken by women and lasts up to three years, and 27 % of women are on

parental leave longer than Formánková et al., Plasová & Vyhlídal, 2016). That alone does not explain the lower aspiration of women. Further, is describes the impact of (expected) childbearing and parental leave has on the professional development of young female physicians.

In the Czech socio-cultural setting, women consider what parenthood will mean for their career development and what their work will mean for their family life. While choosing their specialisation, 32.2 % of female physicians considered how possible it would be to combine it with family care. Also, 23.63 % of female physicians recognise that gender impacted their selection of specialisation. They recognise that their decisions are affected by the expectations and perceptions rooted in socio-cultural structures related to their gender. It illustrates the perpetuating gender contract described by Simerská (2000) as a set of implicit and explicit rules governing gender relations, distributing differing work, values, responsibilities, and duties to women and men. Women in 2000, when the study was made, primarily stayed on parental leave with children, which remains. However, young female physicians recognize that they experience gender discrimination, recognizing that a gender contract is in place. 62.11 % of female physicians think that their career options would be better, since women still predominantly go on parental leave, and women spend on average four hours more than 4 hours more than their partners (Table n.1).

It is also relevant to explore gender stereotypes about men and parental leave since only 1.8 % of men go on parental leave. In Czechia, there are three types of support for parents: maternity leave before and after giving birth, paternal leave for fathers, and parental leave. Parental leave refers to providing care for a child for up to three years. However, people almost always call parental leave „maternity leave“. In the testimonies, all the respondents used maternity leave to describe parental leave. Even though this social support for parents is gender-neutral, incorrect label prevails. Butler (2006) highlighted the connection of people’s understanding of what is male and female affected by culture and language (Butler, 2006). This label presupposes parental duty and parental leave to a parent of a specific gender. The respondents themselves participate unknowingly in perpetuating the expectation for female physicians to leave for some period of their work to take care of a child. However, they recognise that this assumption negatively influences their development of skills and the possibility to attend training or reach certain positions.

Respondent 331 shared, „Men get more opportunities to develop in the surgery because they do not go on maternity (no one thinks that male physicians could leave for maternity leave).“ The supervisor automatically expects young female physicians to leave the workforce at some point. This is a recurrent pattern in the testimonies of used arguments to excuse discriminatory behaviour towards female physicians. The testimony continues, „At the same time, my male supervisor does not recognise a colleague-man who takes care of his minor child twice a month so his wife and physician can go to work at that time.“ (R311). Gender stereotype applies to a man judged by his superior for deviating from the expected gender division of roles. It also shows how fixed are the expectations based on gender about parental duties. The male physician is perceived in a negative light that he takes care of his child, deviating from expectation. on masculinity.

Pregnancy

Regarding the experience with workplace discrimination in the workplace 47.26 % of female physicians were asked during their job interview whether and or when they plan to have children. The expectation of pregnancy is a recurring theme among the testimonies, often

affecting opportunities of young female physicians. The shared experience touched several areas:

1. **Limited opportunities because female physicians are expected to go on parental leave sooner or later**.

„ I was told that I would not be accepted for the internship because 'it does not make sense since I will go on maternity leave. " (R14)

„Interview - whether I plan children when I have a grandmother. At the end of the interview, they told me that I would be accepted only if there was no man; the senior doctor would prefer men because he does not go on maternity leave. " (R169)

Both respondents are expected to have a child. Respondent 14 does not get the opportunity to do an internship, which can negatively influence when she obtains her medical licence. Respondent 169 is expected to not only have a child, but they already asked her indirectly if she has somebody to help her take care of the child. The person who should be the help, possibly in cases of sickness, as will be explained later, is female. The interviewer expects the responsibility for care from the mother and grandmother. The presumption based on gender roles is also made about men, which are not expected to go on parental leave. This statement places women and men into binary oppositions.

*2***. Comments, jokes, and questions regarding pregnancy**

„Inappropriate remarks on my (female) colleagues and me about potential pregnancy, "jokes" like let's dilute their contraception pills into the water. "(R79)

„A month after graduation, I was the only one who got married, so I was constantly asked if I was pregnant. " (R228)

3. Penalization after the announcement of pregnancy to superiors.

„A female colleague told the former head physician she was expecting a child. After this announcement, the head physician wanted to take her personal (financial) evaluation, but the colleague refused to sign the new salary assessment. " (R227)

„*Repeated attacks on colleagues for their pregnancy. " (R333)*

„Firing my female colleague at the clinic and inpatient care on the same day as she announced she was pregnant. " (R190)

4. Low staff

„3 years married female colleague announced that she was in the 6th week of pregnancy and that she would go on maternity in 7 months, announced the head physician, who subsequently scolded her bad way 'how she did not let her know earlier, why did she think that she will not work nightshifts, why did she return to workplace when she got pregnant after a year in this position." (R58)

„Negative reactions (about pregnancy) and evoking a sense of guilt for leaving the maternity leave, leaving the work team and that someone else will have to work instead of them." (R300)

The parental leave, or the absence from the workforce, is perceived as unfavourable and even punished. Firing a pregnant employer, for example, is forbidden in the Labor Code. The negative reactions to the announcement of pregnancy is related to lack of physicians and already extreme working hours and overtime. In section four, respondents described the blame pregnant employers experienced. The guilt is highlighted by the statement that „someone else will have to work instead of them" (R300), attributing them the responsibility on low staff on them.

Statement of respondent 58 also showed, that pregnant physicians are expected to work nightshifts, which follow the working they and last in average, up to 26 hours. The Sekce mladých lékařů started to draw attention to the extended practice that pregnant physicians are pressured and coerced to work nightshifts (following workday)(Sekce mladých lékařů, 2023). Pregnant employers can not work overtimes, even if they wanted to, and certainly not if they do not want.

The possible absence of female physicians or their limitation in work due to pregnancy, therefore, impacts the senior physicians, who try to refrain from employing or giving opportunities to female physicians. The Czech healthcare struggles with the low number of physicians, and feminisation of healthcare is continuously described as a problem, for example, by the president of the Czech Medical Chamber, Milan Kubek (Deník referendum, 2020), „The continued feminisation of the field is a problem and another dangerous trend. Female doctors do not work as much because of family reasons. Just because a woman is a doctor does not mean she stops being a mother." His and the statements of senior physicians above show the awareness that the issue is impacted by parental responsibilities, which are predominantly assigned to a specific gender. All these aspects are presented in the following testimony:

„Unfortunately, in the Czech Republic, for many workplaces, gender is a question of life and the death of the workforce. If, for example, most working physicians are women, they often stay at home with a sick child (they do not solve it at home and stay with them), and many other female and female colleagues must cover for them. Unfortunately, it is too familiar. Czech healthcare is based on overtime, and the loss of every physician can be a problem." (R298)

The respondent highlights the issue of understaffing of the healthcare system, which is based on overtime in connection with the parental responsibilities of female physicians. The focus is on the female physician as a responsible person for 'not solving it at home'.

Discriminatory practices, some of which were described above, support why women are often discriminated against - the lack of physicians, which creates more pressure and a hostile environment and legitimises the perpetuation of gender discrimination. Through the lens of feminist theory, the disadvantaged position of women within the labour market is both a consequence and a reflection of the patriarchal structure and the subordinate role of women in society and the family (Anker, 1997).

However, the system does not support mothers to return from parental leave easily, 94.48 % of young female physicians and 75.56 % of young male physicians think that better conditions should be provided for returning to work from parental leave in the health sector (Table n. 6). 45.54% of workplaces provide kindergarten or day-care (Table n.6). Respondent 67 highlighted this issue in her statement, „ I do not see room for reducing gender discrimination until systemic support of maternity." However, if female physicians are perceived as a threat to healthcare system, instead of professionals who in this current setting of parental leave, need support in their return to work, the situation will not change for the better.

Respect and value of opinions

The bias towards female physicians' professional views was explored; 48.45% of women felt that their colleagues value more opinions from people of different genders, while 46.75 % felt that way about their superiors (Table n. 3).

„The same idea said by men and women. " (R:35)

„One of the older male colleagues has a habit of unnecessarily digging into the diagnostic conclusion of a female colleague from neurology in a way that crosses the line because he mentions that he does not trust her because she is a woman. " (R328)

Respondent 328 recognized that his female colleague is underrated by one of the older male colleagues and has to face unnecessary advice about diagnostics made by her. Women experience that their input and abilities are underrated. Young female physicians shared that during interviews or personal assessments, they were told that men would be prioritised due to women leaving for parental leave. But a question arises: why are women taken less seriously and less respected? It points to the subordinate position of female physicians due to discriminatory structures rooted in patriarchy (Anker, 1997). The lecturer at the university told 71.58 % of young female physicians that they should not pursue a particular specialisation due to their gender, 23.29 % heard it from somebody close, 24.32 % from colleagues and 17.12 % from senior physicians (Table n.5). These comments are rooted in gender stereotypes and perpetuate them by negatively influencing how young female physicians perceive themselves, their capabilities, and their options.

Gender bias also impacts the respect toward female physicians; 70.79 % stated that their gender affects the amount of respect they receive, and 97.04 % feel less respected than men (Table n.3). Female physicians mentioned in testimonies that they experienced less respect from patients or lower staff. Respect is connected to degrading comments about people due to gender; 63.91% of women encountered such remarks, 44 % of men (Table n.3), 65.9 % targeting women and 6.5 % gender nonconforming people.

Lower respect, together with experiences with underrating professional opinions of female physicians can impact the decisions of female physicians, meaning their decision would be connected to their experience of gender. However, as stated earlier, only 23.63 % of female physicians recognised that gender could affect their decision about specialisation (Table n. 1).

Development of professional skills

Young physicians need to learn in-practice procedures and develop needed skills. Due to the specialisation examination, they must fulfil specific obligations related to their specialisation. The period when they fulfil the requirements and can go to the specialization exam depends on the willingness of the employer to provide the necessary resources and support. After completing the specialisation training, graduates must pass the state specialisation examination (atestace) to practice independently (Stará, 2012).

52.92 % of women feel they have fewer opportunities to develop their professional skills. Prior research described that female physicians experience gender bias during their residency training (Spina & Vicarelli, 2015); fewer female residents receive mentorship and opportunities to develop skills (Yaghmour et al., 2021). The study highlighted the significance of the autonomy given to surgical residents to make decisions and exercise independence during their training, impacting their skills development, confidence, and future careers. (Meyerson et al., 2017). However, as illustrated earlier, female physicians are underrated in their skills and have loss possibilities due to the possible pregnancy and parental leave.

61.64 % of female physicians said gender discrimination occurs in professional development (Table n. 7)[2]. The testimonies most often mention that women are given fewer possibilities to

[2] 180 : 292 /100 = 61.64

learn. Some women are directly told that it does not make sense for them to develop their knowledge because they will leave due to pregnancy; other experiences mention only hearing that they are not men, and some do not mention it.

R40: Rejection of consultations, rejection of cooperation

R72: Repeatedly, more often, men are sent for internship. The same thing happened with the training of specific complicated procedures or services in the ICU; in all cases, men were preferably accepted/sent.

R115: It is much easier for a male physician to get to learning opportunities/supervision for specific procedures, which often leads to a faster learning curve (possibly due to a non-existent learning structure in the workplace) and a self-fulfilling prophecy. Moreover, men's mistakes, unlike women‘s, are usually considered "bad luck" and "chance" and not as insufficient knowledge/skill.

Respondent115 generally describes lower access of female physicians to developing their skills; from her experience, the perception of mistakes caused by men is perceived as a deviation based on bad luck. This perception is rooted in expectations linked to gender, expecting men to do a good job and the expectation that women are less skilled, which is proven by a mistake made by female physician.

She continues to highlight the result of a „self-fulfilling prophecy“, being aware that expectations are posed on women about their skills and capabilities to be physicians due to their gender. She disclaims that these expectations would be true. However, she acknowledges that, at some point, male physicians get ahead of their female peers, not due to their capabilities, but opportunities to professionally develop.

Compared to the findings in Simerská (2000) about female physicians, female physicians in 2023 are aware of the functioning of a „gender contract“, showcasing explicit and implicit rules for governing gender relations in different institutions of society. Gender contracts affect resource access to develop skills that maintain a specific social order (Gibson et al., 2018). Respondent115 identified this gender structure, which legitimises discrimination against female physicians further for example, in accessing higher positions and wages, which is discussed later.

Forsberg (2010) connects gender contracts with the evolvement of societal power relations through conflict and negotiation. However, these processes can burden the discriminated group, which can be complicated due to dependency on employment. Their possibility to negotiate, in the uneven distribution of power due to their gender and age, complicates it.

Czechia faces a credibility crisis of trade unions and the under-developed role of professional associations (Healy & McKee, 1997); therefore, it is not so common to organise to ensure the decent or improvement of workers' conditions. This can be illustrated by the general conditions of Czech physicians, including 26-hour long working days several times a month (Mladí lékaři, 2023), which are against the Labor Code. The respondent 298, earlier in the text, acknowledges that „Czech healthcare is based on overtime, and the loss of every physician can be a problem.“

The lack of organisation of physicians or female physicians can lead to the perception of those that raise issues regarding their conditions or inequality within the institution or healthcare system as deviation or individual problems connected to a person or the workplace. This

highlighted one of the respondents: „Discrimination exists only at specific workplaces. “ (Table n.7). One of the options was „I do not think there is gender discrimination “ (Table n.7); however, the respondents acknowledged to some extent the experience of those who faced gender discrimination, probably based on stories from his surroundings. Nevertheless, the answer denies the possibility of joint or even systemic problems.

Professional development has, as mentioned earlier, an impact on employment opportunities. Admission to employment was chosen as an area where gender discrimination occurs most often; 84.93% of female physicians chose this option. It was also often mentioned in their testimonies, „After starting employment, my male colleague (who started on the same day) had better opportunities. After a few months, when they saw that he was not so skilled, they assigned me to the surgery room just as often as him “(R114). Respondent114 received the same opportunities after the superiors realised her male colleague was less capable, which led the female physicians to receive comparable opportunities. More female physicians recognised this issue and described their experience, „At one interview, I was openly told that although I was the most capable candidate, I would only be accepted if a man did not log in to a specific time. “ (R14) In this case, it was explicit discriminatory assessment during the interview. The acknowledgement that her skills are above average. However, she can still be disqualified from getting the position, which sends a message about how the possibilities for her career grow. The statement shows that men, without considering their skills, are more likely to be accepted into employment. Another respondent highlights the precariousness, „The (female) doctor is repeatedly given a fixed-term contract “(R56). The employer does not have security that they will not be fired. This experience is described by respondent 171; she was let go after her supervisor found a man for her position. All these examples show the limitations in accepting female physician to the workplace, these negative experiences can lower self-esteem and raise helplessness, affecting further perception of possibilities to success in pursuing leadership positions.

Wages

The wage gap between men and women is 12 % in the age group from 25 to 29 and 13 % in the age group from 30 to 34 years (ČSÚ, 2022). 55.82 % of female physicians recognised that wage is one of the areas in which gender discrimination occurs. This is described by respondent 67, „women are left to less prestigious part of the field“, is one of the components that influence higher wages of male physicians since more prestigious fields are connected to higher wages.

The issue of unequal pay can be assigned to different issues; for example, women are less skilled in negotiating salaries, and men are stereotypically perceived as breadwinners and have better positions for negotiation (Newman, 2011). To some extent, these assumptions shed light on the issue. However, these described aspects are set in patriarchal structures and expectations fixed on gender. On the other hand, there are further aspects to be explored; women are less likely to be hired, and more likely to ask to work part-time (Rimmer, 2014), this illustrates that women are discriminated based on their gender, however, this discrimination occurs within complex structures that leave small space for an individual to negotiate. Women are also more likely to have experienced discriminatory or demeaning comments or treatment, which can influence their confidence to negotiate (Newman, 2011).

This was described by respondents in the short text; respondent **76 described the experience with lower wages more, „**For example, the doctor (man) just before the specialisation exam received the same rewards as a doctor (female) with 15 years of experience, she has been working for a long time.“ The experiences, training and examination of female physician is not valued, even though it means a lot of work. The response mentions rewards, which is connected

to personal performance. Since it is based on subjective assessment, it is hard to prove that gender discrimination, in the legal sense, occurred. This issue is discussed later in the text.

This witnessed experience can affect the young female physician, further strengthening the determinism connected to her gender, in other words, accepting the subordinate position, or supporting her perception as less valuable and demotivating her. On the other hand, it can support her in pointing out the injustice and to secure fair pay. However, in 2011, a senior female physician lost in court despite being paid half the wage than her male peers (Šimáčková et al., 2020). Such a result can be discoursing and lead to acceptance of the order.

Unequal pay is forbidden by the Labour Code, and in state-owned healthcare institutions, it is based on income classes fixed by the level of education and experience. However, unequal pay still occurs. Concealing different wages can serve as a personal reward, which is more complicated to prove that it is based on discriminatory practice. The argument concerning the gender pay gap and unequal pay in Czechia is that such a thing cannot exist because the employer would choose the cheaper employee. However, the expectation that female physicians will leave for parental leave and will have to take care of sick children and other gender stereotypes set in patriarchal structures, women can be perceived as less valuable workers. This can be recognised through the level of respect and value of their professional views, as mentioned earlier, and showcased in experiences, „The male doctor without specialisation exam supervised the female doctor with the completed exam. “ (R243)

Sexual harassment

Sexual harassment is one of the displays of discrimination based on gender and a tool to strengthen gender inequality in the labour market (Křížková, a další, 2006). Female physicians recognised sexual harassment as one of the forms of discrimination in 43.49 % (Table n.7).

58.41 % of female physicians experienced unwanted sexual remarks about themselves in the workplace and 64.94 % about another person (Table n. 3) Respondent127 described that her experience with sexual harassment changed her view on sexual comments, „I have learned that I should not let sexual wanna-be jokes, which is always the beginning, and I object immediately and forcefully. “ This testimony points out the potential danger of unwanted sexual jokes. They reflect the despect towards women and that they are perceived as sexual objects. Since it is just a joke, people tend to overlook it and belittle the negative impact it can have on a person. However, the sensitivity to „jokes “that devaluate people as objects are reminder of women’s oppression. Calling out such comments sets boundaries. It is also a signal to a person who makes these jokes, that it is not okay. Women who object can be often perceived as being too sensitive, which serves as an argument to dismiss pointing out that it is not appropriate.

Female physicians experienced unwanted touching at 22.76 %. They dealt with the situation/s in the following ways: most of them, 79.1 % „did not do anything“, 59.7 % „objected“, 52.23 % „talked about it with my colleagues“, 38.8 % „did not do anything because they knew nothing would change“, 14.92 % „left the workplace“, 7.46 % „talked with superiors“ and 7.46 % „did not mind“.

The possibility of resolving sexual harassment in workplace, according to Křížková (2006), depends on the capacity of the victim and the capacity and tools of the institution to resolve such problem. Only 5.63 % of respondents stated that „their workplace has support systems or tools in my workplace to address gender discrimination and sexual harassment“, and 56.67 % did not know. The way sexual harassment is resolved, therefore, depends on the individuals and their views and approach toward this issue in institutions. Men displaying power over someone are more likely to be perceived as in place, including sexual harassment (Johnson in Cleveland

& Kerst), which influence to what extent is sexual harassment accepted and overlooked and whether the supervisors, or colleagues recognize it as an issue. Generally, resolving sexual harassment with superiors is not so common (Křížková et al.,2006). Many senior physicians and superiors are men, and people who experience sexual harassment by men can experience fear from men and mistrust. In the case of respondent R287, the experience of sexual harassment led to „Distrust of male colleagues ".

Sexual harassment can often be perceived as a private matter, ignoring the crucial role of power relations in this issue. It serves as „an expression of power and dominance and a mechanism for protecting or enhancing one's sex-based social status. This conduct reinforces the existing gender hierarchy, a hierarchy that privileges men." (Bedahl in Cortina & Areguin, 2021, str. 287)

Most respondents who endured sexual harassment decided not to do anything. The position of young female physicians in the workplace is sensitive due to their positions as graduates. Respondent R224 shared, „Women without specialisation examination are victims of older male senior physicians and are afraid to object. " This example highlights the intersection between gender and age in the discrimination of female physicians. They experience sexual harassment due to their gender; however, because of their age connected to obligations to obtain a medical license, they fear jeopardising their further professional development. If the perpetrators are supervisors, like in this case, this can affect access to mandatory internships and procedures, generally professional development. Such experience was described by respondent 67, „I fear suggestions that opportunities will come in exchange for a 'physical act.' "This follows the pattern when their supervisors coerce young female physicians to submit to sexual acts. The same experience was shared by respondent 187, „The senior physician proposed "more friendliness" so that I would get to the surgeries. "These women work in different specialisations and regions; however, the formulations are alike. The inappropriate proposal is framed positively by the person harassing, mentioning positive outcomes – „opportunities will come "and „I would get to the surgeries ". Suggested sexual favours are described indirectly, and these words are not in the Czech language are usually used to describe sex. The tone is positive, not showing pressure or a threat, instead offering access to further develop their skills. However, respondent 67 described being worried because she is aware of the outcomes such a situation could have for her. The people who gave such suggestions are supervisors, who make decisions about their access to professional development, which is prior the specialisation exam important. The power disbalance is more evident, as was reflected indirectly by the Respondent 224. In case of sexual harrassment the possibilities to say no are limited and can have a negative impact, therefore the use of the word „victim" to describe young female physicians without the specialisation exam who are sexually harassed, is suitable, it refers to powerlessness.

In cases such as these the institutions should have procedures and tools to tackle sexual harassment, since the victim can not turn to their supervisor. The senior physicians are probably not using their position of power for the first time and without some structural approach to these situations, the senior physicians will continue with their unpunished harassment. Current situation does not provide the young female physician with tools to resolve the situation, other than leaving.

Responded 63, who talked about her experience with sexual harassment with her supervisor physician faced negative consequences instead of the perpetrator, „Fewer possibilities for career growth. An austere approach to leadership. More and worse service. "In the end, the punished person was the young female physicians, reinforcing helplessness and mistrust in the system. Reaction legitimises sexual harassment in the workplace and sends a signal to the perpetrator

that their mistreatment is not a problem, or is even natural based on gender stereotypes. It also strenghten the passive role of women showing them that they should accept it. Křižíková (2006) highlighted that women are stereotypically asses with passive role and as object of leas, whereas men are assigned due to their gender proactive role. The sexual harassment and its acceptance supports inequal power relations based on gender.

In this experience, 38.8 % of female physicians „did not do anything because they knew nothing would change, "illustrating mistrust that the matter could be resolved, fear and submission to the power structures in place.

Sexual harassment in the workplace has a negative impact, such as stress, lower confidence, a decrease in mental health and a higher chance of changing employment (Cortina & Areguin, 2021). Respondent 143 shared that sexual harassment led to „lower self-esteem, self-worth and faith in my abilities and education ". Sexual harassment disturbs the integrity of a person and devalues them. In this case, the experience enforced a subordinate position.

To change of workplace decided 14.92 % of female physicians who endured sexual harassment, one of them was respondent 294, who shared how it impacted her, „I was bullied by a senior doctor who taught echocardiography; I ran away and gave up echocardiography because of it." Leaving the workplace reflects the hopelessness of young female physicians and the negative impact it had on them. Data from US show that women who experienced sexual harassment were 6.5 times more likely to change their employment than their counterparts without the experience (Cortina & Areguin, 2021).

Specialisation, leadership and gender

Earlier were presented data about whether gender played a role in female physicians' decision about specialisation; most of them did not recognise the impact of their lived experience based on gender. However, 71.58 % young female physicians heard at university from lecturers that some specialisations are not suitable for women (Table n.5). Respondent 67 shared that „Women are left less prestigious parts of the health care, reminders that opportunities come just because I am a woman." (R67) Women in the first sentence are in passive form, suggesting the lack of possibility to participate on the decision in what field a person works. Men are less likely to occupy the less prestigious fields since they have better chances of being employed, leaving the less prestigious specialisation to women. Even though the data suggest otherwise, respondent 67 is reminded repeatedly that it is not her skills and hard work that secured her employment, undermining her value. From earlier presented testimonies, women's experiences are more often rejected from employment due to a preference to employ men. „ Leadership positions are automatically ascended based on gender (to men)." (R49)

For young female physicians, a male-dominated field can mean more sexual harassment (Křížková et al., 2006), resulting in the women leaving such an environment, strengthening gender inequality, or even the field as described respondent 294 stated earlier. Further respondent 83 shared,

„We (women) have been told at the internships that we cannot be good obstetricians, for example, because "this is not a job for a woman because it requires thinking, quick decision and strength, and a woman is not capable of that."

Respondent 83, during an internship, experienced discriminatory comments related to obstetrics due to the described limitation assigned to the female gender – „thinking, quick decision, strength ". The female physicians experienced discouragement about one field. However, the statement generally undermines the capabilities of female physicians that can influence their work in any field. This statement is rooted in and perpetuates gender stereotypes.

Respondent 162 shared her experience as a female surgeon. „They changed female surgeon to male surgeon, considering her focus on detail in patient care too feminine and unnecessary; young women are often treated worse; and in the surgeon room, they more often shout at female physicians; I have the feeling that they think we are incapable. I ignore comments that women should not be surgeons daily by older colleagues. (R162) She summed up different discriminatory practices in her testimony, from comments to rude behaviour towards female surgeons based on gender stereotypes. In this case, femininity is interchangeable with negative, and it was used as an explanation for why they let go of the female physicians. This statement is rooted in the essentialist perception of skills and attributes based on biological sex. This statement mirrors the patriarchal structures, highlighting that femininity is connected to less valuable skills and work approaches. This statement can be interconnected with care stereotypically assigned to women. However, in healthcare, these attributes should not be perceived as negative. And maybe this so-called feminine care could be from this essentialist perspective an explanation to why female surgeons have a lower death rate within 30 days after surgery (Wallis, 2017).

Newman (2011) highlighted that female physicians in leadership positions have lower confidence than their male colleagues and are more cautious to apply for promotion or leadership roles. However, the research did not address the context of society and culture, perpetuating discrimination against women. The experiences with bias shape female physicians' confidence or underestimation (Meyerson et al., 2017; Morisson & Fowler, 2020; Yaghmour et al., 2021).

Women are underrepresented in senior management roles within the healthcare sector. The latest numbers, which is from 2002 showed that women were directors in 23 out of 201 hospitals (ÚZIS,2002). Women make up more than half of the physicians. However, the assignment of distinct characteristics based on societal perceptions of masculinity and femininity, influences what the expectations about the characteristics of person in charge are.

Higher number of male physicians in leadership positions is natural, accounting their success to their skills, which may be true; however, their gender privilege had an impact on their access to develop professional skills in chosen and more often more prestigious fields, as illustrated earlier, to be employed, or promoted more likely, due to the way pregnancy and parental leave is perceived and also handled in Czech society the families and state structures.

In many areas, men have most leadership positions in Czechia; they are perceived as the norm based on their characteristics. Young male physicians see and have many supervisors of the same gender, having role models. Their presence is perceived as natural, and people often assign to leadership positions stereotypes that follow the gender stereotypes about men, for example, that they have stiff elbows, they are though. The success is accounted fully to their capabilities. The privileges are often not addressed, limiting the space for reflecting gender power relations, patriarchal structures, and perpetuating discrimination.

The theory of gender contract does not reflect on the limitations of subordinate groups to negotiate. The reflection of patriarchal structures and the subordinate role of women can explain the cyclical character in describing different aspects and influences of gender discrimination and its impact to one another, if women are given fewer opportunities due to possible pregnancy, that affects the skills that prove that women are less capable, fewer job opportunities. However, women predominantly have children, this does not mean it should be a justification for not adjusting the system for half of the population, which would also help reduce the working hours of physicians.

4. Conclusion

In conclusion, young female physicians in Czechia experience gender discrimination in their work. Directly described the experience of 68.28 % of female physicians; in most of cases, they received limited opportunities. 28.08 % of young female physicians want to pursue leadership positions. The hypothesis that young female physicians are discriminated against based on their gender was approved by the obtained data. The women's low interest in leadership positions and the wide range of gender discrimination correlate. However, the qualitative data could not prove the causality that discrimination leads to lower aspiration.

due to their age and gender when women are expected to get pregnant and stay with the child at home. However, this presumption, which frames parental leave, negatively influences the future development of their skills and reassessment of specialisation.

Gender discrimination has different forms; however, their tendency is to increase the gap between male and female peers in access to employment, more prestigious specialisation and growing unequal pay.

Since the university female physicians were told that due to their gender, certain specialisations are not for them, such experience described 71.58 %. Further, they described generally less opportunities to develop in their field, 52.92 %. Usually, the reason was fear that female physicians would get pregnant and leave. It represents the expectation that women will have a child and they will stay with the child at home on parental leave, which reflects 98.2 % of cases. However, even if the woman did not want a child or her partner would stay with the baby at home, the expectation related to gender prevailed. On the other hand, a case of a father who stayed partially with a kid at home was not accepted by his supervisor, as this deviated from the rooted expectations about masculinity. However, the respondents themselves did perpetuate gender stereotypes in all their testimonies when they used maternity leave, which is something else; however, in Czech society, people almost always refer to it as maternity leave. It shows the rooted expectations on the women to be the one who stays at home.

Pregnancy and parental leave, or the absence in the workforce, is perceived negatively. It is influenced by the fewer physicians in hospitals, who must take night shifts (following working day), which can be up to 26 hours. Pregnant women, after their announcement in work, experience different forms of punishment such as scolding, lowering personal financial assessment, fired. Pregnant women are blamed for the problem with fewer staff and are expected to continue working overtime and night shifts. However, giving more opportunities and making more accessible return from parental leave, could provide some support to the healthcare system,; in reality, it is not like that; 94.48% of young physicians think that it is needed to provide better conditions for returning to work from parental leave in the healthcare.

Gender discrimination is a product of gender bias, which refers to inclinations based on stereotypes. Female physicians face less respect; 70.79% recognized that due to their gender, they are less respected than their male colleagues and their professional opinions are less valued by colleagues 48.45 % and by superiors 46.75 % women.
This poses a question: if parenthood was the only cause of discrimination of young female physicians, why would they experience bias underrating their professional views and receiving less respect?

The feminist theory describes that the disadvantaged position of women is consequence and a reflection of the subordinate position of women in patriarchal structures. They affect the position of women within all structures of society. The unequal position results in different

access to knowledge and skills. Through the lens of feminist theory, the causality relation between discrimination, which strengthens the power relations, it is expected to be that way.

92.76 % of young female physicians most often recognized that gender discrimination occurs in regard to access to general opportunities, which include their possibility to develop skills and further access to employment. The opportunities translate into wages and access to leadership positions. 84.89 young female physicians recognize that gender discrimination occurs in relation to their wages. Certain specializations, usually the more prestigious ones, are perceived as unsuitable for women, and young female physicians experience remarks based in gender stereotypes rooted in patriarchal structures that underrate women. Discouraging experiences impact their aspirations; more concretely, the experience with reoccurring discrimination on the basic level of employment can lead to mistrust and disappointment that reinforces gender inequality.

In relation to the intersection of gender and age, the experience of young female physicians with unwanted sexual comments and unwanted touching with a sexual undertone shows that they face double marginalization. Examples from respondents showed that they experience unwanted sexual proposals from their supervisors, who decide about their possibility of fulfilling requirements to get to the specialisation exam. These experiences cause fear and also affect leaving the workplace or field.

In conclusion long-term gender discrimination affects the aspirations of many young female physicians to pursue leadership position. As a by-product of discrimination, the healthcare system results in fewer physicians instead of supporting professional development and adjusting the support system to make the return from parental leave easier to allow earlier to work.

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Apendix A

Table n. 8:

Affect of sexual harassment
Q25: If the experience affected you, please write how.
R34:There were 2 two senior doctors; for both of the experiences it was one (albeit not the main) reason for leaving the workplace (identifies as a woman)
R37: I objected a second time (identifies as a woman)
40: I experienced all the experiences with gender comments during internships, and I chose my home department precisely because such things do not happen there. I will continue to limit cooperation with people who discriminate against me in some way. (Identifies as a woman)
R63: Fewer possibilities for career growth. An austere approach to leadership. More and worse services. (Identifies as a woman) R67: I fear suggestions that opportunities will come in exchange for a physical act. Fortunately, things calmed down for me after my relationship with a colleague of the same age came to light, but I'm still not sure
R103: It must be added that the person who harassed me, not "in the true sense of the word" my colleague (I work in the urology department, we have beds because the surgery department is closed, and the harassment came from the surgery doctor) (identifies as a woman)
R118: I do not want to say (identifies as a man)
R121: I avoided certain activities (identifies as a woman)
R127: I have learned that I should not let sexual wanna-be jokes, which always start with them, and I object immediately and forcefully. (identifies as a woman)
R130: It probably did not affect me. Perhaps now I object earlier and more forcefully in case of inappropriate behaviour (identifies as a woman)
R143: It lowered my self-esteem self-worth and faith in my abilities and education
R168:Empathetic (identifies as a man)
R179: It contributed to considering a change of workplace. (identifies as a woman)
R205: We had intercourse later (identifies as a man)
R270: I was so shocked that I could not react (identifies as a woman)

R287: Distrust of male colleagues (identifies as a woman)
R294: I was bullied by a senior doctor while teaching echocardiography; I ran away and gave up echocardiography because of it. (identifies as a woman)

Table n. 9:

Opportunities
R298: Unfortunately, in the Czech Republic, for many workplaces is question of gendre is a question of life and the death of the workforce. If, for example, most of working physicians are women, they often stay at home with a sick child (they do not solve it at home and stay with them) and many other female and female colleagues must cover for them. Unfortunately, it is a prilis caste. Czech healthcares stand on overtime and the loss of every doctor can be a problem. R311: Men get more opportunities to develop in the surgery because they do not go on maternity (no one think that man physician could leave for maternity leave). At the same time, my male supervisor does not recognize a male colleague-man who takes care of his minor child 2 days a month so his wife and doctor can go to work at that time. R331: When residential place was assigned, the head physician unambiguously stated that 2 graduates (man and woman) would come, so it is clear that the man will het the place to pamper him .. When applying for participation in the outpatient component,a debate with the same head physician took place that I want children and I will go to maternity leave, he claims that it is nonsense before the specialization exam, that I will close all the doors, that I have to do it first and then devote myself to the family.
R4: My female colleagues are preferably sent on Surgereon internships and, on the contrary, are not listed for the operating room or are not accepted at all (this has changed over the last year). One of many examples.
R7: Different inappropriate comments
R13: women are not let to do certain procedures
R14: At one interview, I was openly told that although I was the most capable candidate, but I would only be accepted if a man did not log in to a certain time. Furthermore, at the previous workplace I was told that I would not be released from the internships because, it does not make sense to go on maternity leave
R38: Sexist language of older colleagues
R40: Rejection of consultations, rejection of cooperation, sexualization
R49: For example, the preparation of the educational events (man are compensated, young female physicians not because they will leave for maternity leave), leadership positions are automatically assinded based on gender.

R54: Women with the female senior doctor are easier to head for internships and reach personal bonuses earlier. Men are often more respected from patients.
R55: A man is preferred at interviews. Men have a drive contract
R61: The head accepts the colleagues - a man into his working group.
R63: Not giving possibilities to go to the ICU for the majority of female physicians. More men on the outpatient department than women
R67: Women left to less prestigious part of the field, reminders that opportunities come just because I am a woman Orthopedics is specific in this, but in other fields I do not see room for reducing gender discrimination until systemic support of maternity.
R68: Men are more often attending surgeons, women moved to the outpatient clinic
R72: Repeatedly are more often men sent for internship. The same thing when with the training of certain complicated procedures, or services in the ICU, etc.in all cases were preferably accepted/sent men
R74: At the interviews are considered only male candidates. Female physicians have harder carreer growth.
R75: Senior doctor (female) repeatedly prefer male candidates. When (male colleagues) they show same level of knowledge as their female peers in the same period of education, it is recommended to female physicians to give more professional attention to the male colleague and not to bully him. Harder possibilities for female colleagues to return from maternal leave, unwillingness to reduce the workings hours and unwillingness to support earlier return to profession sooner then after 3 years, even though she (senior doctor) returned to work for part time soon after having a child. On top of that her statementt: "Girls, you are so skilled, a shame that none of you is men".
R76: I think they are classic comments of superiors about wanting to accept men or complaining from older female colleagues who finished their specialization exam and who have less rewards or the same for more work. For example, the doctor (man) just before the specialization exam received the same rewards as a doctor (female) with 15 years of experience, she has been working for a long time,
R114: After starting employment, my male colleague (who started on the same day) had better opportunities. After a few months, when they saw that he was not so skilled, they started to assign me for the surgery room just as often as him.
R115: It is much easier for a male physician to get to learning opportunities/supervision for certain procedures, which often leads to a faster learning curve (this is possible duet to non-existent learning structure in the workplace) and a self -fulfilling prediction. Moreover, men's mistakes unlike women‘s, usually considered "bad luck" and "chance" and not as an insufficient knowledge/skill.

R116: I was at the same time as a male colleague, after the specialization exam and his personal evaluation increased personal evaluation. In discussions about involvement in work projects, the argument is used that the woman will soon leave on maternity leave so it is not worth to involve them and teach.
R118: Women will go through everything and have much more more options from learning medicine or in perception by the patients, men have a problem breaking stereotypes
R119: The residential position was offer
R135: choosing of new physicians – always men becuase the do not go for maternity leave (meant parental leave)
R126: They prefer to hire men. They have also higher wage.
R127: Prioritizing male colleagues for the surgery room.
R130: Male colleagues are prioritized in selecting courses, they have a higher salary, even if they have lower education
R135: choosing of new physicians – always men becuase the do not go for maternity leave (meant parental leave)
R141: Men are preferenced in a selection procedure because they do not leave on maternity
R142: The man was let to go on internships and in the ICU before and without begging than female colleagues
R149: Men are preferably accepted for the position.
R152: Selection of job seekers, selection of the head of the department
R160: I was promised to develop the in other specialization, I left for acredited facility for a year and half, after that I was told that the specialized position was offered to male colleague (who will leave for acredited facility) becuase I was away and I will have children.
R162: The change of female surgeon to male surgeon, because it would be too much for a woman considering that the pursuit in detail care for patients is too feminine and unnecessary, young women often more unpleasant, in the surgeon room they more often shout at female physicians, I have the feeling that they think we are incapable. Comments that women should not be surgeon is on daily basis, being ignored by older colleagues
R168: Preference of male doctors over female doctors for various positions and functions or employment; passive and verbal aggression towards doctors who dared to conceive; degrading comments to male doctors who decided to go to switch with their partner on parental leave

R170: My first supervisor got rid of me after a trial period because he had men for the position
R171: Clear preference of men as surgeons over women - women are used to cover „patches“ in the shifts
R177: Repeatedly giving preference to a man before a woman because "a guy stays". Personally, for several years I have sought to change the work of the place with the aim of greater specialization (within the same workplace), I was satisfied only when the senior doctor did not find doctor - a man who would want it.
R179: In surgical fields different numbers and types of surgical performance and space in the surgery room.
R185: The opportunity to try something new got a colleague - a man.

R188: Priority for even less capable male colleagues in professional growth just because they are men and I will go to maternity leave. A warning that female doctors who feel they do not want to do night shifts becuase of children should consider if they should continue working in the hospital. The message of the head of department that we need the right sex - that is men. Warning of the head physician of the surgical field that he likes women, but does not want to work with them. Warning at the interview, although I am not a star, but certainly quite smart and especially good looking to get a place there…. . Etc etc many and many and many situations of my acquittances.
R196: Accepting man for a position for which significantly more qualified woman applied
R200: The senior physician wants to employ mostly men; he also does not want foreigners, but I think it is common
R212: For example, senior physician employs new (male)physicians becuase „ from young female physicians one does not what to expect, then directly or indirectly preferes male physicians and assigns them to certain procedure
R216: Women were repeatedly underratted during the surgery internship.
R202: Male colleagues were prioritized at the surgery room.
R221: My deadline for the specialization examination because my trainer realized that I do not have enough practice after after six and a half years of practice that I did not have enough procedures and I would embarass the workplace if I left. It is first time that this is disscussed on our workplace, it happened to colleague and that they would never do that to a man even if he was not trained eenough and whose fault if was that they did not assign me to more complex procedures? And the interview with the trainer began: we know that gender exists and it was also made clear to me that if I wanted to do hepatopancreatobiliary surgery, that for sure

not at this workplace, it is forbiden for all women in the inpatient care Fortunately, I am not interested in HPB, so it doesn't bother me.
R222: More opportunities, the opportunity to develop in the field, preffered colleague of opposite sex
R228: Personal experience, all men were automatically accepted in the selection procedure, followed by women with connection and then only those with an interesting CV, applicants from Slovakia had no chance. A month after graduation, I was the only one to get married, so I was constantly asked if I was pregnant. My colleagues who came with me got a fixed inclusion in the department, the educational plan, the offer of scientific activities and personal evaluation and reimbursed conferences. I got twice the nightshifts and moved me, where it was necessary to justify that I certainly do not plan to work for a long time and it is not worth supporting me somehow. When I refused to drink alcohol with the senior physician at the conference, a rumour spread that I was pregnant, in two months I was informed that my contract would not extend the although I work well and nobody complaines, stating that it will be better for me to enjoy my family life for the first time. I left, it had health and psychological consequences for me. I was the only one who had already worked in science during my studies, I was in psychotherapeutic training and published. It wasn't enough. Pregnancy came after all this, originally I had planned not to have children, but this experience for a long time convinced me that under these circumstances work in healthcare is not worth it. For several years I worked outside of health care and did not encounter any discrimination.
R234: Repeatedly the preference of Less capable (several times and really incapable) men before a capable woman when he is admitted to the clinic. Men's significant preference in intensive care – it was hard as woman to get opporunities. Much less opportunities for example for manual performances, because I am a woman (compared to lesses skilled men).
R240: At the former workplace, if a doctor - a man wanted to go to the course, "that's great that you want to move on" when a woman wanted to go to the doctor "I have to see if we can occupy the halls or what Atls, we are not a trauma center"
R243: 1. The male doctor without specialization exam supervised the female doctor with the attestation.
2. Male doctors have a higher basic salary and evaluation than femalle doctors, despite doing the same work.

3. Doctors always have priority over the female doctors when they want to go to a course, internship or conference.
R269: The head physician repeatedly prefers to employ male physicians then female physicians.
R275: Distributing rewards only among men in previous jobs
R280: At the interview, I was told that they prefer men.get more responsibility at the intensive care
R281: Men have always been financially better evaluated than women who performed an equal or even higher position. Also, men's requirements for leadership were mostly heard so that men would not leave (but it usually did not work) - financial, education, career procedure, etc.
R309: Male doctors are perform surgeries, they have the possibility of professional development, they have more competencies regardless of female physicians at higher job positions (or specialization egam), leadership does not hide that boys are the future of the department
R335: As young male physician and before medic, I met meny times with unwillingness of older colleagues to pass their experience – for men I am not interested and younger male colleagues they wont devote the time (they would not give time to female physicians becuase they are women) However some of my female peers are attractive for the male superiors and the female superiors supported them based on solidarity, they had more opportunities without less effort. They left us (men) stand in the hall and „MS physicians“ could look. During studies I did months of voluntary internship so I would learn, nevertheless I did not reach the same amount of procedure as my female peers who rarely did some extra work. It led me to change the surgeon specialization.
R24: Development options, Wage
R335: As young male physician and before medic, I met meny times with unwillingness of older colleagues to pass their experience – for men I am not interested and younger male colleagues they wont devote the time (they would not give time to female physicians becuase they are women) However some of my female peers are attractive for the male superiors and the female superiors supported them based on solidarity, they had more opportunities without less effort. They left us (men) stand in the hall and „MS physicians“ could look. During studies I did months of voluntary internship so I would learn, nevertheless I did not reach the same amount of procedure as my female peers who rarely did some extra work. It led me to change the surgeon specialization.

Table n. 10:

Sexual harassment / sexual comments
R187: The senior physician proposed "more friendliness" so that I would get to the surgeries
R123: Untasteful remarks of the senior doctor to female colleagues, lower Financial Asseestment.
I have witnessed and positive discrimination of gays who had a very strong representative at our clinic and were objectively prioritized by the professor of the same community
R224: A woman without specialized examination are victims of older male senior physicians and are afraid to object.
R191: Warning of the head physician of the surgical field that he likes women, but does not want to work with them. Warning at the interview, although I am not a star, but certainly quite smart and especially good looking to get a place there…. . Etc etc many and many and many situations of my acquittances.
R135: choosing of new physicians – always men becuase the do not go for maternity leave (meant parental leave) R137: My older colleague came to radiology assistant and put his head between her breasts and shook his head between the breasts.
R256: I heard from my female colleague's teling a story that her colleague (older man) addressed her to the phone "You bun" or "if such kitty would call me, as this one, I would even come right away. Personally, the file exceptionally.
R296: Remarks to female colleague about their private life
R312: Inappropriate comments, men are preferred
R315: Refusing to let the female doctor for internship because she got married/has a long relationship/has age = certainly pregnant. During the interview when I posed the question to access to mothers doctors (eg part -time, employee nursery) I was cut off the list. Innapropriate behavior in pregnancy comments. Aggression of patients towards female staff.
R212: For example, senior physician employs new (male)physicians becuase „ from young female physicians one does not what to expect, then directly or indirectly preferes male physicians and assigns them to certain procedure

Table n. 11:

Parenthood
R34: Men's preference at the interview, preference in the professional ambulance, allowing only men to take a course, constant questioning of women when they go to maternity, literally I was personally told that I would not be given the leading position, I was the only one with the qualification because I'm sure I'm going to go to the maternity, not allowing the return of my colleague from the maternity to work part -time part -time
R20: If possible, they accept men because they don't give birth.
R46: I am constantly listening that I will get pregnant and leave and that I chose a bad industry for a woman. When I need something, then again, if we want (women) the emancipation, I have to cope with it. Constantly allusions to what I look like I don't even have to mention
R58: 3 years married colleague announced that she is in a 6th week of pregnancy and that she would go to maternity in 7 months, announced the head physician who subsequently scolded her in a pretty bad way (as she can afford to not know before, as she will not do nightshifts, Why did she ever get on the workplace when pregnant- after a year in this position). Furthermore, with other colleagues quite indiscriminately dropped colleagues who are married this year, etc.
R79: Inappropriate remarks on me and my (female) colleagues about potential pregnancy, "jokes" like let's dilute their conctraception pills into the water.
R86: Doctors (men) often receive the opportunity to go to compulsory internships before their older female colleagues. In an effort to get the same rights, I and several other colleagues were told that we should have other priorities than a career, obviously meant to have family soon. The doctor (female) whom complained to superior that she would not be able to finish specialization exam in time, was told it is because of large number of colleagues (men) who needed an internship (although she was there the longest from the group) was by superior (I think in good faith) downright "advisable" solutions to get pregnant and when she returns the situation will be calmed down
R109: The question for the family situation during an interview clearly discriminatory. if I said that I want a child in five years.
R134: Always comments in the style of why I let her go to an internship instead of a younger colleague if she has children in a moment.
R160: I was promised to develop the in other specialization, I left for acredited facility for a year and half, after that I was told that the specialized position was offered to male colleague (who will leave for acredited facility) becuase I was away and I will have children

R169: Interview - whether I plan children, when, if I have a Grandmother. At the end of the interview they told me that I will be accepted, of course only if there is no man, he would be prefered, because he does not go on parental leave
R188: Priority for even less capable male colleagues in professional growth just because they are men and I will go to maternity leave. A warning that female doctors who feel they do not want to do night shifts becuase of children should consider if they should continue working in the hospital.
R190: Firing my female colleague at the clinic and inpatient care on the same day as she announced that she was pregnant (after unfortunately miscarried, none of the above mentioned but was not returned), I was extremely upset (man)
R227: Female colleague announced the former (female)head physician that she was expecting a child. After this announcement, the head physician wanted to take her personal evaluation, but the colleague refused to write off the new salary assessment.
R215: Womene experience consant questions about pregnancy, planned parenting, if they find out that you want to get pregnant, they will skip you in education…
R228: Personal experience, all men were automatically accepted in the selection procedure, followed by women with connection and then only those with an interesting CV, applicants from Slovakia had no chance. A month after graduation, I was the only one to get married, so I was constantly asked if I was pregnant. My colleagues who came with me got a fixed inclusion in the department, the educational plan, the offer of scientific activities and personal evaluation and reimbursed conferences. I got twice the nightshifts and moved me, where it was necessary to justify that I certainly do not plan to work for a long time and it is not worth supporting me somehow. When I refused to drink alcohol with the senior physician at the conference, a rumour spread that I was pregnant, in two months I was informed that my contract would not extend the although I work well and nobody complaines, stating that it will be better for me to enjoy my family life for the first time. I left, it had health and psychological consequences for me. I was the only one who had already worked in science during my studies, I was in psychotherapeutic training and published. It wasn't enough. Pregnancy came after all this, originally I had planned not to have children, but this experience for a long time convinced me that under these circumstances work in healthcare is not worth it. For several years I worked outside of health care and did not encounter any discrimination.
R246: The trainer asked me whether I plan pregnancy at our meeting, instead of introducing the plan of further education. It was a very unpleasant situation, because these questions were asked infront of my senior doctor at the assessment meeting.
R248: The senior doctor: I prefer to employe men, girls get pregnant, fall out or return. I need someone to stay here

R253:Women do not perform operation, they are not offered with education and development, because it is automatically assumed that they will go to maternity leave and then they will have to take care of children, OCR, etc.
R270: Questions at the interview, who will baby sit my sick children. Returning from a professional internship to the inpatient department for the lack of doctors, while the younger male colleague sent from this department for professional internships. Male colleagues are proceeded faster to the internship needed for the specialization exam. Despite the lack of doctors for invasive procedures, female physicians were rejected when they applied for a permanent popsition at these workplaces, men were accepted immediately. Already at all statements like: a woman does not belong to medicine, maximum pediatrics, you have nothing to do here, you will give birth to children anyway
R294: A man was appointed to by the vicehead position only with exam (kmenová zkouška prior specialization exam), although my older friend, a woman, was just before the attestation (the environment of the district hospital, the internal department, with the specialization exam was only the head physician), during half the year she successfully finished the specialization exam. However, the position was not even offered. When she got married, the head physician took her position as a leader, because "he will certainly have children soon".
R300: Prefferably employing male doctors over women physicians, which was openly communicated at interviews. Repeated questions and public questions about family planning and pregnancy in the work environment - either with the person present or without their presence.Negative reactions and evoking a sense of guilt for leaving the maternity leave, leaving the work team and that someone else will have to work for them.
R304: My current female head physician has female colleague she prefers. On the contrary, male colleagues (and I) have it tought ... This is one of the reasons why I will leave soon.
R306: Female doctors are repeatedly delayed in professional development due to (anticipated, possible, hypothetical) pregnancy.
R333: Repeated attacks on colleagues for pregnancy, contracts for an indefinite period and the possibility to go to internships more for male workers
R249: If you were a guy I would employ you.
R111: I wasn't right there. But my colleague described that when he was at the interview, the senior doctor openly told him he had an advantage because he was a guy.

Table n. 12:

Value
R35: The same idea said by a men and women
R54: Women with the female senior doctor are easier to head for internships and reach personal bonuses earlier. Men are often more respected from patients.
R56: The (female) doctor is repeatedly given a fixed -term contract
R57: The ICU manager complained in front of me that there was no guy in the workplace to whom he could pass on his knowledge. Although he knew I was interested in the ICU and his knowledge. We were a workplace full of young girls. No guy came there until now
R83: - I have been assigned some unpleasant work because I am a woman (and that it is a job for "gentle female hands" that no man is suitable for).
- We (women) have told at the internships that we cannot be good obstetricians, for example, because "this is not a job for a woman because it requires thinking, quickly decision and strength, and woman is not capable of that"
R109: The question for the family situation during an interview clearly discriminatory. if I said that I want a child in five years. Respect from lower staff to female doctors is in some cases scarce.
R143: At orthopaedics, I could not examine the patient, or the voluntary practice and the argument was that is not for women, I was addressed as a barbine several times who is not fit for the field, in surgery they do not pay as much attention to female physicians as to male physicians
R328: One of the older colleagues has a habit of unnecessarily digging into the diagnostic conclusion of a neurologist's female colleague in a way that many he crosses the line becuase he mentions that he does not trust her is very probably because she is woman.
R329: Non-expansion of the contract for a female colleague for no obvious objective reason.
R337: I was accused by an elder surgeon that as young internist I am not experienced, and I do not know what I am doing (he told it to my patient). IR4t is necessary to say that as a gynecologist I experience from some midwives and a clearly expressed despect that I do not have to talk to the birth. But it happens at least.

Sexual harassment
Q25: If the experience affected you, please write how.

R34: There were 2 two senior doctors; for both of the experiences it was one (albeit not the main) reason for leaving the workplace (identifies as a woman)
R37: I objected a second time (identifies as a woman)
40: I experienced all the experiences with gender comments during internships, and I chose my home department precisely because such things do not happen there. I will continue to limit cooperation with people who discriminate against me in some way. (Identifies as a woman)
R63: Fewer possibilities for career growth. An austere approach to leadership. More and worse services. (Identifies as a woman)
R103: It must be added that the person who harassed me, not "in the true sense of the word" my colleague (I work in the urology department, we have beds because the surgery department is closed, and the harassment came from the surgery doctor) (identifies as a woman)
R118: I do not want to say (identifies as a man)
R121: I avoided certain activities (identifies as a woman)
R127: I have learned that I should not let sexual wanna-be jokes, which always start with them, and I object immediately and forcefully. (Identifies as a woman)
R130: It probably did not affect me. Perhaps now I object earlier and more forcefully in case of inappropriate behaviour (identifies as a woman)
R143: It lowered my self-esteem self-worth and faith in my abilities and education
R168: Empathetic (identifies as a man)
R179: It contributed to considering a change of workplace. (Identifies as a woman)
R205: We had intercourse later (identifies as a man)
R270: I was so shocked that I could not react (identifies as a woman)
R287: Distrust of male colleagues (identifies as a woman)
R294: I was bullied by a senior doctor while teaching echocardiography; I ran away and gave up echocardiography because of it. (Identifies as a woman)

Table n. 13:

Comments about minorities
R75: Harder possibilities for female colleagues to return from maternal leave, unwillingness
R109: The question for the family situation during an interview clearly discriminatory. if I said that I want a child in five years. Respect from lower staff to female doctors is in some cases scarce. Remarks from some colleagues (again mostly lower staff) to nonbinary people, transgender issues, homosexuals, refugees, etc. (expressions of the type "they are not people", "it does not exist", etc.) - I absolutely do not want to discuss it because I have no ambition to change their views and I do not have time to waste time with them, but I perceive it very negatively.
R193: Inappropriate jokes about Homosexuals and Transgender people, and minorities (roma people)
R214: I have witnessed the humiliation of gays. Although a colleague is obviously clever, he is simply gay and thus cut a branch under him.

Apendix B, tables

Appendix

Apendix C, charts