Gender Relations, Seniority Structure, and Subjectivities in Surgical Training in Istanbul, Turkey

by

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ABSTRACT

THESIS TITLE: Gender Relations, Seniority Structure, and Subjectivities in Surgical Training in Istanbul, Turkey

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This thesis examines gender relations in surgical training in Istanbul, based on 20 interviews with medical interns, i.e., senior medical students who are about to get their undergraduate medical school degree and doing internships in different medical specialties in hospitals. Through focusing on *the seniority structure* in medical school, the study argues that the traditional organization of medical education, based on unequal power relations (re)produced by the strict seniority hierarchy, creates gendered hierarchies and abusive power relationships between medical professionals. After examining various social conventions the seniority structure includes, it attempts to understand everyday gendered relations in surgical training, which put women in a disadvantageous position compared to men, who are considered natural occupants of surgical specialties. Examining everyday gendered practices and discourses in surgical specialties shows that these practices and discourses shape the experiences and subjectivities of medical interns and affect their specialty choices, leading women to give up the idea of being a surgeon, even though a high proportion of women enter medical school with the goal of getting into surgical specialties. In the gendered context of surgical training, women are both tacitly and openly directed to non-surgical specialties as they are accepted to be "fragile" and incapable of dealing with the harsh requirements of surgical training where *survival* and *challenge* are rewarded concepts. Moreover, while this context discourages women medical interns from choosing surgical specialties, it encourages men through male bonding. However, this thesis does not put women into a passive position. It also focuses on women's criticisms of surgical training and analyzes the subversive practices of women and LGBTI+ medical students, who are getting organized to deconstruct gendered conventions and dismantle gendered organization of medical school and surgical training.

Keywords: gender, gendered hierarchies, surgical training, medical education, women in medical profession.

ÖZETÇE

TEZ BAŞLIĞI: İstanbul'da Cerrahi Eğitim Alanında Toplumsal Cinsiyet İlişkileri, Kıdem Sistemi ve Öznellikler

Heval Yaren Şimşek

Bu araştırma İstanbul'da cerrahi eğitiminde cinsiyet ilişkilerini, stajyerlerle, yani tıp fakültesi lisans diplomasını almak üzere olan ve hastanelerde farklı uzmanlıklarda staj yapan son sınıf öğrencileriyle yapılan 20 görüşmeye dayanarak incelemektedir. Araştırmanın amacı, cerrahi bölümlerdeki eşitsiz cinsiyet ilişkilerini incelemek ve kadınların cerrahi bölümleri seçme/seçmeme kararlarını nasıl ve neden aldıklarını anlamaktır. Çalışma, tıp fakültesindeki kıdem yapısına/hiyerarşisine odaklanarak, bu hiyerarşi tarafından yeniden üretilen eşitsizliklerin cinsiyet temelli olduğunu ve istismara açık güç ilişkileri yarattığını ileri sürmektedir. Kıdem sisteminin yarattığı çeşitli sosyal kabuller ve gelenekler incelendikten sonra, cerrahi bölümlerin "doğal" sahibi kabul edilen erkeklere kıyasla kadınları dezavantajlı bir konuma sokan gündelik ilişkileri anlamaya çalışmaktadır. Cerrahi uzmanlık alanlarında gündelik cinsiyetçi pratik ve söylemler incelendiğinde, bu uygulama ve söylemlerin tıp stajyerlerinin deneyimlerini ve öznelliklerini şekillendirdiği ve uzmanlık tercihlerini etkilediği gözlenmiştir. Kadınların büyük bir kısmının tıp fakültesine cerrah olma hayaliyle girmesine rağmen gündelik güç ilişkilerinin kadınları cerrahiden vazgeçirdiği görülmektedir. Kadınların "kırılgan" ve "çiçekler" olarak tanımlanması, baştan bir sosyal kabulle yeterli görülmemeleri, cerrahinin zorluklarıyla baş edemeyecekleri önkabulünü getirdiği anlaşılmıştır. Üstelik bu bağlam, kadın tıp stajyerlerini cerrahi uzmanlıkları seçmekten caydırırken, erkekleri de üst kıdemli erkeklerle yakınlaşma ve dostluk kurma yoluyla teşvik etmektedir. Ancak bu tez kadını pasif bir konuma sokmamaktadır. Aynı zamanda kadınların cerrahi eğitime yönelik eleştirilerine ve sosyal olarak örgütlenmelerine de odaklanarak, cinsiyete dayalı sosyal kabulleri yapısöküme uğratma çabalarına bakılmıştır.

Anahtar Kelimeler: toplumsal cinsiyet, cinsiyetli hiyerarşiler, cerrahi eğitimi, tıp eğitimi, tıp mesleğinde kadınlar.

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CHAPTER 1: INTRODUCTION

In a conference talk by DRx Ege Tıp, released as a YouTube video, a woman surgeon tells her story of getting into general surgical training after passing the TUS (Medical Specialization Examination) and choosing to be a surgeon. She is now in her 60s; therefore, the time she got into general surgery was more challenging for women medical students. She describes how masculine the environment was while she was the only woman among approximately seventy-five men, i.e., professors and trainees. According to her experiences, surgical specialties are male-dominated areas where patriarchal norms and rules prevail. She says men joke about football and women and use associated slang words in everyday life of surgery. It is a command-and-control hierarchy as if you are in a military sphere. She argues that this was the nature of the working environment in surgical specialties. She adds that her aim in getting into the surgery was not to challenge or change it. She acknowledges that she must act according to the existing rules and regulations in surgical specialties because her seniors were her masters. Her only aim was to get accepted by her seniors as one of them.

In our *Qualitative Research Methods* class in my first year of graduate school, the professor, who is now my thesis advisor, asked me whether I would be interested in writing my thesis on gender relations in surgical training as she knew that I was interested in social studies of science and medicine. Then, I did a preliminary interview with someone I knew personally, a senior medical student. While discussing gender discrimination in medical school and surgical training, two fellow students of my friend working as interns in the same hospital joined us. They used concepts like “male domination” in the medical profession, the “command-and-control system” of seniors, and the “military-like environment.” However, they seemed to acknowledge the existing environment like the woman surgeon I mentioned did. Even though one tries to oppose injustices and inequities, it is believed that this person would not be

allowed to take patients, participate in operations, or practice. Since the acceptance of male domination came from a senior woman professor and current students, it seemed that many generations had internalized gendered hierarchies.

It is crucial to contextualize the historical development of biomedical knowledge and practice in Turkey to understand what the concept of a "military-like environment" means for surgery and surgical specialties in Turkey. According to Ceylan (2012), surgery was separate from physicianship until the 19th century. For many years, surgeons were trained by being an apprentice of another surgeon. Most of the time, the surgery as a profession was handed down from father to son (pp. 64-65). After the establishment of the first medical school in 1827, the classification of surgeon-physician emerged, and surgery was incorporated into official medical education (p. 68). The first medical school, *Mektebi Tıbbıyeyi Askeriye* (Faculty of Military Medicine) was founded to meet the needs of the military. The ordinance of Sultan Mahmut II shows us the military's need for physicians and surgeons: "We need to train mastered doctors for both our soldiers and our empire" (p. 67).

More importantly, teachers/masters of this military medical school were also soldier-surgeons of the Ottoman military who were sent to combat zones during times of war. In his article on the historical role of medicine in Turkey's modernization project, anthropologist Christopher Dole (2004) argues that medicine as a domain of late Ottoman state practice emerged institutionally linked to the military reforms with the aim of modernization in order to remain competitive with European powers (p. 259).Thus, we can suggest that this marks the historical origin from which the military tradition gradually disseminated into the realm of surgical training[1]. The first surgeons of the late Ottoman period were trained in military-medical

[1]Interestingly, it is still called "*taburcu olmak*" in Turkish for being discharged from hospital in everyday language. *Tabur* can be translated as "troop" in English. To be discharged from hospital, therefore, has a connotation with being discharged from military, ending of the service. Thank Professor Ayşecan Terzioğlu for evoking this aspect and giving this example in her feedback to my thesis.

schools, where the military command-and-control system merged into the organization of surgical training. This shows us that the claims of the woman surgeon in the YouTube video and the current medical students that surgery is a military-like environment have a historical base.

When we come to the historical development of biomedical knowledge and practice in the Republic of Turkey, Dole argues that "the Ottoman state's successor fully embraced the incorporation of modern disciplinary techniques into state" (p. 260), in which modern medicine was a part. Compared to the late Ottoman period, medicine and the expansion of a biomedically based healthcare system were far more critical for the Kemalist modernization process and the republic. Indeed, Dole contends that "the emergence of Turkey as a sovereign political entity and the development of Turkey's medical system were closely intertwined" (p. 258) for building "healthy citizens" and "a healthy nation" to reinvent a national thought and a nation-state "along European lines of science and technology while maintaining its uniquely Turkish culture" (p. 258). In this context, due to the vast significance of biomedical knowledge and practice for constructing a modern Turkish state and citizenry, Turkish medical doctors historically became part of the state-making processes. Therefore, they acquired a privileged position by curing the "illness of society" during modernization (Terzioğlu, 1998; 2008). In addition to the powerful position of a medical doctor as the possessor of authentic biomedical knowledge and competence to apply it to each specific case at hand, the sociohistorical mission of Turkish medical doctors gave them the social prestige and power to be placed at the upper ranks of the Turkish society. Aiming to construct the "new man" of the modern state, as Dole argues, "in the image of the clean, healthy, rational, and scientific-minded citizen" (2004, p. 262), the Turkish medical doctor was to become the exemplary "new man." In this context, we can suggest that the Turkish medical doctor in general and the surgeon in particular were authoritative, sophisticated, and highly educated

male figures, which shows us the Turkey-specific conceptualization of a profession and the sex-typing of it.

In contrast to the historical importance of the "medical man" and the medical profession in Turkey, the interest in medical education and surgical departments is decreasing in today's context[2]. The decreasing interest in a medical career relates to the current healthcare policies initiated by the Health Transformation Program in 2003 and the increasing violence against medical professionals, which is partly due to this transformation and the current healthcare policies, and partly due to the changing understandings of expert-knowledge both in Turkey and the world.

Through the implementation of healthcare reform, market elements increased and resulted in the growing presence of the private sector for the financing and provision of healthcare services (Yılmaz, 2017). Moreover, the systematic marketization of Turkey's healthcare sector was instigated by several key factors outlined in Ağartan's article (2015). These are the creation of autonomous health enterprises aimed at increasing competition and choice among patients, the financialization of the public sector through the implementation of revolving funds[3], and the adoption of performance-based payments to public sector doctors. With the inclusion of consumer-provider understanding in the healthcare provision, although access to healthcare seems to have become easier with the high number of patients per physician, the quality of healthcare has decreased in parallel with the decrease in the time allocated to the patient (Tükel, 2017). This is because public hospitals working like an enterprise need more and more patients/consumers to increase the profit rates of these enterprises since their institutional budget depends on the revolving funds and out-of-pocket payments of patients. All these aspects had consequences on the satisfaction of patients and the doctor-patient

[2] https://t24.com.tr/haber/33-tip-fakultesinde-kontenjan-dolmadi,1055970
[3] "revolving funds" is translated as "döner sermaye" in Turkish.

relationship. As Tükel argues, a healthcare system with a high emphasis on the performance-based system and the prioritization of quantity rather than quality caused a provoked demand for healthcare services in society, and therefore, overcrowded hospitals and dissatisfied patients in addition to patients' complaints of increasing out-of-pocket payments.

When we turn to the changing doctor-patient relationship, the disguise of problems in the current healthcare policies directed dissatisfied patients' anger and frustration toward the doctors and other healthcare professionals. According to the Ministry of Health data on increasing violence against healthcare professionals, the number of healthcare workers subjected to violence in hospital settings by patients and patients' relatives was 51,348 between 2013 and 2017 (p. 437). A study of how violence in healthcare affects medical students' opinions on their profession and patients (Yalınbaş et al., 2018) stated that students' concerns about the profession and their future increased, and their motivation to help other people decreased significantly. The authors show that half of the students who participated in the study agree with the statements of, "If I am exposed to violence, I would lose my courage for medical decision-making," "I would become alienated from patients," and "I would not prefer to treat risky cases" (p. 155).

The medical professionals and their professional associations criticized the effects of the current healthcare policies on medical schools and the quality of medical education. According to the Istanbul Medical Chamber, in order to make more money for the medical and pharmaceutical industry, the current healthcare policies prioritized therapeutic instead of preventive medicine (Ömeroğlu, 2022). Since this provoked a vastly growing demand for healthcare services, medical faculties and student quotas increased. Thus, Turkey's number of medical faculties has tripled in the last twenty years (Yavuz, 2023). However, infrastructural improvements could not meet these increases. Instead, private and unqualified universities emerged, academic positions remained vacant, and the quality of medical education decreased

(Ömeroğlu, 2022). As a result, the medical profession, which once occupied the top social and professional prestige in Turkey, fell into disfavor.

However, in the context of immense changes in the profession and the healthcare system, the traditional organization of medical school, especially surgical training, reproduces and maintains its military roots, as my interviewees repeatedly likened disciplining practices of surgical training to military discipline. Therefore, we can suggest that surgery and surgical training carry two meanings in their social and educational baggage. Firstly, it comes from a military tradition whose traces can be found in the strict seniority structure in which professors are like commanders, and each person as a senior toward the ones who came later is also like a commander. Thus, they can treat their junior as they wish. This social image of the surgeon as a commander can not considered independently of gender. It is a male commander in Turkey's context. Thus, the worldwide image of surgeons as arrogant, aggressive, and active male figures finds validation and meaning in the historical remnants of the relationship between surgery and the military in Turkey. Secondly, however decreasing in importance, the Turkish medical doctor and surgeon is still a highly authoritative male figure who once was on duty to be exemplary for the Turkish citizens and patients. Throughout the pages, I will elucidate how the interviewees had experiences that substantiate the social meanings mentioned above, which can be attributed to this historicity of the medical profession in Turkey.

In this context, my initial question became why change towards gender equality was so little and slow in surgical specialties while we observed the mainstreaming of gender-related issues in many industries and civil society as much as gender-related topics started to be discussed in medical education. Why does change seem impossible or unnecessary for different generations of medical professionals? How and why do the historical remnants of military-medical relationship persist, which is non-egalitarian and highly hierarchical?

In my fieldwork, I conducted face-to-face and online semi-structured interviews with twenty-two medical students who were in their last year of undergraduate degree and were recently graduated. However, because of technical problems, I could not reach the audio records of the two interviews. Therefore, my research is based on interviews with twenty medical students from Istanbul between February and May 2023. I used snowball sampling to create my interviewee group. My sample group includes fifteen women and five men medical interns. In Turkey, undergraduate medical education comprises six years of anatomy, biology, and natural sciences classes and compulsory and elective internships in hospital settings. In their last year of undergraduate education, medical students spend their two semesters in different branches of medical practice as interns. Even the ones who do not plan to pursue a surgical career become interns in one or more surgical specialties. Then, new graduates either prepare for TUS (Medical Specialization Examination) or they choose to become general practitioners in hospitals or family medicine centers. The ones who want to specialize in different branches of medicine have to get into residencies whose years of training change depending on each one's requirements.

I chose to conduct my interviews with medical interns because interns are in the process of deciding which medical specialty they will select depending on their internship experiences. The relative weight of good and bad experiences during internships highly influences their career choices. My research showed that the ones exposed to more abusive relationships during internships in surgical specialties often give up the idea of specializing in surgical departments. Thus, the gendered character of this process will be revealed through medical interns' accounts in this research. Secondly, as medical interns are at the lowest rank of the seniority hierarchy, they are more likely to be overwhelmed by the seniority structure and tell their stories to me. Moreover, as they are fresh minds in medical school and about to be team

members but still not yet, they are more sensitive to the arbitrary decisions their seniors make in medical school.

My interviewees' age is changing between 24 and 26. Thirteen of the interviewees were from a private university in Istanbul, and seven were from a state university in Istanbul. Having interviewees from both a private and a state university enabled me to compare them and understand whether there was a difference. My research showed that there was only relatively less strict hierarchy in private universities. The fact that medical education is traditionally based on a master-apprentice relationship showed that all interviewees experienced their seniors' abusive behaviors to varying degrees. However, an egalitarian medical education and a horizontal organization of members of the medical school seemed nearly impossible, whether it was a private or state university. Thus, as I will discuss in the subsequent pages, private and state universities convey many continuities regarding the seniority structure and gendered relations.

There are several limitations of this thesis that I need to address. First, I touched upon how the lives and bodies of LGBTI+ patients are framed in the normative structure of medical school and how LGBTI+ medical students are affected by the gendered seniority structure during medical education. However, my understanding of the subversive practices of women and LGBTI+ medical students is based on social media platforms and LGBTI+ medical students' manifesto, interviews with civil society organizations, public demonstrations shared on Twitter, and so on. Therefore, my research lacks first-hand empirical data on LGBTI+ experiences. As my sample group is composed of cisgender women, further research is necessary to acquire knowledge and data on the experiences of trans women and gender-nonconforming people.

Another limitation pertains to the lack of the subjects' social class differences and analyses of them. I did not ask any questions about people's socioeconomic status, how it might

contribute to their oppression, and how gender and class intersect. As we cannot melt the experiences of women from different socioeconomic backgrounds into a pot, expanded research taking the intersectionality of class and gender into account will be fruitful to see differences and injustices in the experiences of women from different socioeconomic backgrounds. For instance, in a private university where thousands of Turkish liras are spent on education fees, several women students come from a lower socioeconomic background and earned full scholarships in these universities, and their experiences of gender inequality cannot be totally understood from a gender perspective only. Even though private and state universities convey many continuities in terms of the traditional gendered structure of surgical training, from the subjects' perspectives, the hardships they face in professional and everyday life might be more complicated than this research provided.

To analyze the interview data, firstly, I used thematic analysis to categorize the recurring themes in the answers of my interviewees. Then, I analyzed their narrative structures and attempted to contextualize what they experienced and observed in surgical training and medical school.

Throughout my interviews, the interaction between me and my interviewees, and the surrounding in which our encounter occurred, from the cafeteria in a private university hospital to video calls, shaped the flow of our conversation. After an interview with a specific person finished, sometimes I realized that I had forgotten to ask the particular question in my mind or that I repeatedly asked the same question with different wordings. However, the question could not make sense to an interviewee as he did not experience anything about the issue. Conversely, sometimes when a positive bounding happened between me and an interviewee, several new questions and answers to them emerged. The first couple of interviews also shaped and determined my further, more detailed questions for the following interviews. I understood the process as active construction of knowledge, and the interviewees

and I were *active participants in the process*. Holstein and Gubrium (1995) examine, in their article about qualitative research methods and knowledge production, titled *Active Interviewing*, how to grasp the interviewing process, the construction of knowledge, and meaning-making processes by the participants. They argue that the traditional understanding of interviewing sees interviewees as passive subjects from which pure information and life experiences should be taken without "distortion." According to this understanding, data speak for themselves, and subjects are the possessors of the data to be taken from. However, the active interviewing approach grasps the image of the interview "as an occasion for constructing, not merely discovering or conveying, information" (p. 118).

Holstein and Gubrium assert that "the dynamic, communicative contingencies of the interview literally activates respondents' opinions" (p. 118). Rather than understanding my research process in which the "raw" data was taken from the passive subjects to be interpreted by the researcher, our interaction started unfolding our situated experiences and knowledge about our social worlds. When women interns told me that they sometimes felt invisible and interpreted the approach of senior professors as "not expecting too much from women," I felt the necessity to start asking who were the visible ones. In a context where survival and challenge are rewarded concepts, which students achieve survival and overcome the obstacles and how they do that became significant questions. The following questions were what kind of social environment this picture created and who benefited more. In an interview during which I provided my initial grasp of the situation, a woman intern told me that she thought about what I said for the first time, but it made sense when she turned to her past experiences to see the resemblances.

Chapter 2 focuses on the seniority structure and unequal power relations it creates and enforces in surgical training in Istanbul. The seniority structure and hierarchy have powerful senior male actors who want to maintain the existing privileges and limited opportunities.

These relations put women students and interns in a disadvantageous position compared to men. I argued that the organization of medical school and surgical training, highly enforced by the nature of the biomedical knowledge system and its embeddedness in society and culture, was gendered, which made the seniority structure itself gendered.

Chapter 3 focuses on everyday gendered interactions in surgical training in Istanbul. After I analyzed the conventions, rules, and norms in the seniority structure, I attempted to examine how they affected the everyday relations between people at different ranks of the seniority structure. This approach showed me that the powerful senior actors of surgical training encouraged others to sustain gendered discourses and practices. It was revealed that everyday gendered practices, interactions, and discourses shaped the experiences and subjectivities of medical interns and affected their specialty choices. In the gendered context of surgical training, women were sometimes tacitly sometimes openly directed to non-surgical specialties rather than surgical ones. Women were not seen as equal partners in surgical training compared to men. Lastly, I argued that male bonding prevailed and (re)produced the existing gender-based discriminations against women in surgical specialties.

Finally, in Chapter 4, I focused on the communal and subversive practices of women and LGBTI+ medical students by analyzing social media platforms and their political activities in civil society and medical school. While I used Foucault's understanding of power to analyze unequal power relations diffused in the everyday lives of medical students, I drew inspiration from Biehl and Locke (2010)'s perspective of power and resistance. This is because I, as a feminist graduate student, believe that the existence and subjectivities of women and LGBTI+ medical students cannot be forced into power relations that subjugate them. Their subjectivities and political power are "as much about swerves and escapes as about determinations" (p. 335).

Overall, my thesis attempts to deconstruct and understand the normative structure of surgical training in Istanbul to reveal the construction of gendered practices and discourses. This research enabled me to understand why women were underrepresented in surgical specialties and why they did not feel they belonged to the surgical departments in Istanbul.

I used pseudonyms for all interviewees.

CHAPTER 2: SENIORITY STRUCTURE AND POWER RELATIONS

> "*I will love those who taught me these arts as I love my parents and I will offer my skills to the young with the same generosity that they were given to me. And I will never ask them for gold, but demand that they stand by this covenant in return. I also swear that if I earn fame and wealth, I will share it with my masters and my students*."
>
> Hippocrates' Oath

2.1. Introduction

This chapter examines, what I call, *the seniority structure* (*kıdem sistemi/yapısı* in Turkish) in surgery and surgical training in Turkey. *The seniority structure* or *the seniority hierarchy* (*kıdem sistemi* veya *kıdem hiyerarşisi*) is both formal and informal regulation and organization of medical education and profession. Officially, the seniority structure denotes the organization of ranks and degrees of medical colleagues composed of medical students; interns, i.e., sixth year medical students who are about to get their undergraduate medical school degree; residents who are continuing their specialization training; attending medical doctors who completed their specialization training; assisstant and associate professors; and professors. Informally, the seniority structure denotes the hierarchical organization of social relations and academic responsibilities in medical schools and university hospitals, which creates a command-and-control system between people at different rankings of the formal seniority structure.

Identifying what seniority means and what kinds of traditions, norms, rules, and socially accepted everyday practices and discourses the seniority structure includes are significant to understand unequal power relations and the strict hierarchy of seniority, which is anything but gender-neutral. Examining the seniority structure is very important because its existence and maintenance are indispensable to the construction of gendered discourses and practices.

Therefore, critical analysis of the seniority structure will enable us to grasp how it (re)produces and normalizes the gendered medical culture and education in general and surgical training in particular with its entrenched cultural habits that can be described as patriarchal.

2.2. Medical Knowledge

In this part, I will focus on the relation between the seniority structure and the nature of medical knowledge. This is because the nature of medical knowledge and its embedded uncertainties enforce a strict seniority structure to reduce and control the ambiguities and uncertainties in medical knowledge and practice. In return, reducing and controlling these ambiguities require making certain social and cultural choices to transmit them to medical students in a seemingly unified and cohesive way. These social and cultural choices made by biomedical knowledge system is gendered. The seniority structure enforced by medical knowledge system is also deeply gendered.

Human bodies vary significantly from person to person due to genetic differences, environmental influences, lifestyle choices, and other factors. This variation makes it challenging to generalize findings from biomedical research to all individuals, leading to uncertainties regarding the effectiveness and applicability of treatments or interventions. Patel et al. (2004) describe different reasonings in medicine. While it is agreed upon that there are two basic forms of reasoning, inductive and deductive, they add abductive reasoning to have a more comprehensive understanding of reasoning needed for medical professionals. Deductive reasoning consists of deriving a particular valid conclusion from a set of general premises, and inductive reasoning consists of deriving a likely general conclusion from a set of specific statements. However, they state that “reasoning in the ‘real world’ does not appear to fit neatly into any of these basic types” (p. 5). Therefore, the third form of reasoning, which is abductive reasoning, has been identified as intermixing of the first two. What these authors

imply as the "real world" not fitting neatly into any of these two basic types lies in how biomedical knowledge constructs and understands its objects and the contradictions between the basic premises of biomedicine and its embeddedness in society and culture.

Biomedicine and its assumptions based on the Cartesian dualism of mind/body, culture/nature, and reason/emotion are criticized both in feminist studies and in the literature of critical studies of science and medicine (Taussig, 1980; Scheper-Hughes and Lock, 1987; Lock and Gordon, 1988; Good, 1994; Good, 2001; Washington, 2006). While feminist studies mainly focus on gendered assumptions, the erasure of women's subjectivities and experiences, and the degradation of women's bodies and health in biomedicine (Fausto-Sterling, 1985; Harding, 1986; Martin 1987; Bordo, 1993), critical analyses of science and medicine primarily focus on politics of knowledge and unequal power relations between doctors and patients (Kırmayer, 1988; Fox, 1993; Conrad, 2007). Both concerns are not only unrelated but mostly overlap in terms of how "tenacious" assumptions of biomedical knowledge disguise power/knowledge relations as much as they reveal about health and illness.

Not denying the existence of pain and suffering of patients, Margaret Lock and Deborah Gordon, the two medical anthropologists, argue that "there is, of course, a biological reality, but the moment that efforts are made to explain, order, and manipulate that reality, then a process of contextualization takes place in which the dynamic relationship of biology with cultural values and the social order has to be considered" (1988, p. 7), which is disguised by positivist claims of biomedicine. Rather than acknowledging the cultural and social assumptions embedded in biomedical knowledge, biomedical knowledge claims to be distant from the social world, only engaging with the human body and its parts, a so-called mere biochemical machine. Arguing that biomedical knowledge deems the patient's subjective accounts unreliable and essentially irrelevant to the physical diagnosis, Laurence Kırmayer, a psychiatrist and a social sciences scholar, says "disease stands for the biological disorder, or

more accurately, the physician's biomedical *interpretation* [emphasis added] of disorder, while illness represents the patient's personal experience of distress" (1988, p. 59). When the patient's case is discussed, physical signs are the only part that physicians focus on as if no person is present. However, as feminist critiques show, in the case of gendered assumptions, gender stereotypes and biases can influence the diagnosis and treatment of medical conditions. Women's symptoms may be dismissed, minimized, or attributed to psychological factors, therefore not the concern of biomedicine, which assumes only to engage with the human body and organs in a neutral and objective way.

According to Gordon, biomedical professionals consider sickness a natural occurrence and acquire and enhance their expertise through "a naturalist method" (scientific rationality) and they view themselves as working on the human body, which is perceived as nature's human representative (1988, p. 24). As much as they help the sick and heal them, they conceal their social and cultural choices. For instance, in the famous preface to the Diary of Herculine Barbin, a French hermaphrodite in the 19th century, Foucault (1980) describes the prevailing medical view in Europe that humans only can have two biological sexes. Herculine, upon being discovered to be sexually ambiguous, was compelled to undergo a sex and gender transformation following medical and legal standards of the time. Despite having a healthy personal and social identity as a female, Herculine was required to accept a medical diagnosis that classified her as male, which ultimately led to her suicide a few years later (mentioned in Scheper-Hughes and Lock, 1987, p. 28). As Gordon indicates, this reveals "how biomedicine evolves through social choices rather than a natural inevitability and how, in fact, a sense of 'natural inevitability' or 'givenness' is constructed out of social choice" (1988, p. 20). Therefore, its practices and language are "hardly a simple mirror of the empirical world" (Good, 1994, p. 5). As Good argues, medical knowledge constructs its specialized way of 'seeing,' 'writing,' and 'speaking,' which formulate reality in a specifically 'medical' way.

This specific way of medically knowing the world requires formative processes through which medical students learn to see the world the way biomedical knowledge and profession require. There needs to be certain rules and regulations in medical education to organize the empirical world in a medical way. Reproducing "normal" biomedicine necessitates a highly hierarchical educational and professional structure through which biomedical ways of knowing the world are transmitted to medical students. That way, students are coached to recognize the manifestations of disease, thereafter, the interpretation and treatment of medical conditions. Moreover, the social and cultural choices biomedical knowledge makes are also controlled within the normative structure of biomedicine. And this controlling of the social and cultural choices necessiates a rigorous authority and hierarchy.

To understand how biomedicine reproduces itself in educational processes, the sociologist Paul Atkinson (1988) focuses on medical students' acquisition of competence and the organization of discourse in the framing of clinical understanding and experience. He highlights that medical education is not a process of internalizing a unified body of knowledge but rather involves encountering major features of clinical medicine early on, establishing norms, expectations, and frameworks of understanding. In the "teaching talk" sessions of clinical education, there is a distinctive three-part structure, composed of elicitation (by the teacher), response (from the student), and evaluation (from the teacher), which Atkinson identifies as "chains of talk." He asserts that "this three-part format of teaching talk is very effective for displaying and legitimizing the teacher's authority and superior knowledge. It is a beneficial way not only for eliciting but also for *organizing* the knowledge" (p. 182).

The discourse of medical teaching relies on lists, contrasts, and categorizations to construct the "semantics of 'normal biomedicine'" (p. 183). Teaching physicians prompt medical students to identify relevant signs, symptoms, and differential diagnoses, which help structure

their knowledge. The contrast structures highlight deviations from "universal" biological norms as indicators of disease. Bedside teaching requires students to observe signs and elicit symptoms, which are then interpreted using normative biomedical frameworks. However, novice students often lack the necessary interpretative frames, leading to guidance from the teaching physicians. Thus, Atkinson examines that the production of symptoms involves collaboration between students, physicians, and patients, with physicians coaching students in generating biomedical findings and establishing relevance. However, this collaboration is highly assymetrical as physicians/professors are the ones who hold the power of decision-making while students/novices are the ones who have to rely on professors' words and deeds.

This specific nature of medical knowledge, being embedded in society and culture but disguised through positivist claims, necessiates a narrowing down of the content to shape and determine how to interpret and practice. This is why medical training needs a hierarchical structure. Medical students, i.e., novices, have to acquire the medical gaze and its specifics. They need to learn from their masters how to practice. On the one hand, they need their master's experienced medical eyes, *the medical gaze*, that is again, medical knowledge's specialized ways of 'seeing,' 'writing,' and 'speaking,' which formulate reality in a specially 'medical' way (Good, 1994). On the other hand, the continuity and defence of the medical gaze depends on the control of novices by masters.

In The Birth of the Clinic (1973), Foucault tells the story of the emergence of a new medical gaze in medicine from the 17th to the 18th century. Prior to the birth of the clinic and the new medical gaze in Western medicine, the traditional medicine of these centuries relied on classifying illnesses based on their similarities (*resemblances*) rather than examining the patients and dealing with them as individuals. However, since different people showed different symptoms for the same disease and because symptoms could change over time even within the same body, this classificatory medical gaze was too rigid to accommodate these

changes. Therefore, the medical gaze, the act of seeing, was transformed too. The doctor was endowed with the power of decision and intervention. This medical gaze should grasp every detail in the body, the colors, and the variations: it is now calculating risks and chances. Thus, while the medical gaze is "seeing" every individual, and since the manner in which symptoms manifest themselves differs from one patient to another, the symptom becomes a signifier that speaks the truth of a disease. However, this symptom only becomes a sign beneath a gaze sensitive to difference, simultaneity, succession, and frequency. That is what gives the medical gaze and the ones possessing it the superior power. Now it is the task of the clinic and doctor to turn symptoms into signs while they, simultaneously, teach their students/apprentices to transmit their art and craft.

So far, I looked at biomedical knowledge production and medical gaze to understand the seniority structure and hierarchy in medical training. We can see that biomedical knowledge production is part of society and culture, even though it is claimed that biomedicine is free from social and cultural issues and stands neutral and objective towards them. It has a value-system shaped by societies in which it is practiced. We can comprehend this aspect from varying differences in medical practice in various societies. To substantiate this aspect, I want to mention a well-known practice in Turkey.

The Military Law in Turkey obliges every man who is a citizen of the Republic of Turkey to do military service. According to the health regulations of Turkish Armed Forces, *çürük*[4] *raporu* (the certificate of disability for exemption) can be taken by gay and trans men if their so-called "abnormal" condition is approved as "sexual identity and behavior disorder." For the approval process, Turkey has a long history where gay and trans people had to prove "medically" that they got in "man-to-man sexual relations." The experiences of gay people

[4] It is important to note that "çürük" ironically means "rotten" in Turkish.

included medical doctors' requests of photos and videos taken during intercourse or testimonies of family members, which is far from being "neutral" and "objective." The experiences of gay and trans people show that the approval process is in the hands of homophobic physicians and psychiatrists "where these homophobes became the main executives of these practices, which violate human rights." (Tar, 2018). The request of photos taken during intercourse for a medical report shows us what I mean by differences in medical practice in various societies and what is specific to the social and cultural context of Turkey.

For these reasons, biomedical education requires a strict seniority hierarchy to control knowledge production and social and cultural choices and maintain what is accepted to be true. Moreover, for its continuity and progression, knowledge system and practice has to be transmitted the way seniors themselves acquired the medical gaze during their own trainings. Questionings of biomedical knowledge system and practice are not wanted within medical training. To see how the subjects reflect on these aspects, I will now focus on how my interviewees understand, accept, negotiate, or sometimes challenge the seniority structure, the hierarchy, and their relation to biomedical knowledge.

To begin with, I explored what seniority is and how it operates in different medical specialties where medical students became interns in their last year of undergraduate education. While some legitimize their seniors' authority in terms of possession of authentic medical knowledge and competence in line with what medical training expects from its trainees, others harshly criticize all kinds of strict hierarchies. The majority of my interviewees suggested that the strictest seniority structure and hierarchical relations are at work in surgical specialties, even though all other specialties have seniority structure to varying degrees.

Sema (24) is a sixth-year woman medical student who is currently doing her internship at the psychiatry department and has done an internship in general surgery at a private university in

Istanbul from which she is about to get her degree. When I asked her about the relationship between seniority structure, hierarchy, and the nature of medical knowledge, she explained how the strict seniority structure is justified within the normative frame of biomedical knowledge:

> There is a lot of stuff going on regarding knowledge you have to absorb as a medical student. There are tons of books about disease types, their signs, and potential symptoms that are highly variant depending on several factors. The human body is sometimes like… (she paused for a second) as if it includes a mystery, even though you have all technical numbers and exact procedures done quite well. We must rely on our professors to show us specific directions—at least some easy way-outs.

After this "necessary" aspect of seniority structure, she explained how professors make social and cultural choices to transmit the so-called "objective" and "neutral" knowledge of medicine:

> During my pre-clinical years, I did not come across any objections from my friends in the class. We were not in a state of realization that our professors have some social and cultural biases, and they try to transmit them to us in the name of "science." But things are changing now, and newcomers are aware of the normative aspects of medical education. And they object to what they find problematic in the classroom. For instance, when professors talk about intersex people, they only touch upon the fact that there are intersex people. But it is just an anomaly, an illness. A deviation from the binary structure. They just call it gene mutation. That is it. I heard that objections were taken to the administration, I guess, by the first-year students.

Rana (24) is a sixth-year woman medical student currently doing an internship in general surgery department at a private university in Istanbul from which she is about to get her

degree. She told a story to show how these ways of transmitting knowledge are not gender-neutral, and professors use gender stereotypes to get students' attention. Firslty, her account is important to see how interns problematize the approach of professors and their social choices enforced and protected by the power of seniority. Secondly, it shows how indispensable the seniority structure and the power it provides to seniors are to the construction of gendered discourses in medical school:

> One of my friends told me what happened. In one of their classes, the professor used a sexist advertisement in which "Bayanlara OTOMATIK vites müjdesi!"[5] is written. Just to make students memorize some concepts having first letters coded in OTOMATIK, as a acronym, he used a sexist advertisement saying that women are bad drivers and it is beneficial for them to have an automatic car.

Rana's story about making a sexist argument to get students' attention is useful to understand how medical knowledge and ways of transmitting that knowledge are grounded in the subjective knowledge of the teaching professor. Building upon Hunter's (1991) ethnographic study on the medical practice being also an interpretive task and having a narrative structure, I argue that Rana's emphasis helps us to see how a teaching professor's subjectivity, political stance, or social, cultural, and economic position within the society affect ways of transmitting medical knowledge and the narrative structure they construct in the class. As the account reveals, the gendered assumptions and stereotypes are diffused in educational processes and acknowledged and enforced by the powerful actors of the seniority structure.

When I asked my interviewees about what bothers them most regarding the social and cultural aspects of knowledge given by professors depending on professors' worldviews while they

[5] "Bayanlara OTOMATIK vites müjdesi" is translated as "Good news for women! Cars with automatic gear!"

claimed to take an objective stance, I realized that the majority of women students feel uncomfortable about how lives and bodies of women and LGBTI+ people are framed in the lectures. Candan (26) is a woman who recently completed her internship period and graduated from a state university. She will be a resident at the ophthalmology department at another state university hospital in Istanbul. She complained that there is no specific concern in their curriculum for gender equality or equal consideration for marginalized bodies. She, like Sema, told me how discourses on intersex people are framed:

> The specific issues related to women's bodies, LGBTI+ people, and their health concerns are mostly discussed in psychiatry. Our psychiatry professor was great though. But other than that, there was no mention of them in other courses. For instance, while the professor lectured on endocrine in pediatrics, he said that intersex babies must be operated immediately. He was not even calling them intersex. The word is not used in medical education, at least in Turkey. We call it ambiguous genitalia. I asked the professor whether we should leave the decision to the future when the child grows, so they can decide on their lives. I do not think that he was homophobic or something. He just told me that this is how things are in medicine. This genitalia is different than the *normal* one, so we should make it normal too. Nobody thinks about these kinds of issues too much. They just do.

Her story shows how much space the seniority structure provides to seniors/professors to convey the traditional and socially accepted norms and rules disguised in the form of so-called "objective" science and medicine to medical students. Power and authority provided by the seniority structure allow seniors/professors to (re)produce the existing binary gender system in this example, leading some medical students and interns to question the arbitrary nature of these gendered biases. We see that Candan is asking for the possibility of other ways

of practicing medicine and why biomedical practice makes this specific choice of "normalizing" the intersex body.

During their medical education, while students acquire a range of skills and knowledge necessary for their clinical practice, such as understanding and interpreting physiological functioning through numerical values and lab measurements, Good (1994) highlights that they increasingly become aware of the arbitrary nature of certain activities they are involved in, along with the influential factors that promote conformity. They witness instances where their seniors and professors engage in practices they question. In the above instance, we see that Candan is aware of the arbitrariness of the decision medical practice make for the lives of intersex people. Even if she found the opportunity to question her professor whether they could leave the decision to intersex people themselves for their future, most of the time medical students must comply with requirements of medical school. According to Good, this is due to their junior status and the pressure to maintain the solidarity within the hierarchical system.

Good argues that the learning process takes place within an "extraordinary 'totalizing' institutional setting" (p. 82) where constant evaluation and supervision shape their actions and he finds parallels between medical school, its "totalizing" characteristics, and Foucault's notion of panoptic mechanism, a modern mechanism for regulation and discipline of individuals. To grasp how a totalizing institutional setting looks like, the below excerpt from Foucault is significant:

> "This enclosed, segmented space, observed at every point, in which the individuals are inserted in a fixed place, in which the slightest movements are supervised, in which all events are recorded, in which an uninterrupted work of writing links the centre and periphery, in which power is exercised without division, according to a continuous

> hierarchical figure, in which each individual is constantly located, examined, and distributed among the living beings." (1995/1977, p. 197).

In this totalizing institutional setting, as Good indicates, the evaluation process holds significant power over students' self-esteem where they are constantly supervised. This supervision is not only for disciplining medical students but also for keeping the social and cultural values embedded in biomedicine intact. In this context, while positive evaluations and rewards from those in higher positions can greatly impact their sense of worth, criticism and belittling can undermine it. Thus, Good concludes that hierarchy and the control of the arbitrary, arising from the nature of medical knowledge, are closely related. In this context, where arbitrary characteristics of biomedical knowledge are controlled and maintained through a strict hierarchy in medical training and where gendered rules and norms are reproduced in the name of medical practice while disguising these social and cultural choices biomedicine makes in each society, expecting the seniority hierarchy to be gender-neutral is naïve when we consider how patriarchal the social and cultural context of Turkey is. As the control of the arbitrary works for the control and maintenance of traditional social rules and norms in society, seniority structure can not be thought independent from them as well. In other words, as much as the control of the arbitrary is gendered, seniority structure as the guardian of it is gendered too.

Ardan (25) is a man who is a sixth-year medical student. By the time I have interviewed with him, he was doing his internship in public health at a private university in Istanbul. He did his internship in different surgical specialties before we met and wants to specialize in general or pediatric surgery. I asked him what he thinks about the problems and inequalities embedded in the seniority structure. His account is significant as one of the varying responses of medical students to the seniority structure and to this totalizing institutional setting:

> The problems related to the seniority structure and abuse of power through hierarchical relations are old-time questions for both women and men in medical school. We all know how strict and humiliating the seniority structure can sometimes be. There are discrimination and hierarchy in the seniority structure. These are accustomed part of medical education. I think everyone took a step in accordance with what medical school demands. Everyone has a style to get used to or cope with the unequal relations in this system. Even awful things that happen constantly are normalized. They are part of our everyday lives. People learn how to keep pace with the social order here. Everyone has their own strategies to be able to graduate from medical school. Right or wrong, I do not know.

Ardan seems to acknowledge the "totalizing" aspect of the seniority structure and the hierarchy that regulates social relations in medical training. However, he also normalizes the process and remains passive toward the abusive nature of the seniority structure. This is related to the fact that subjects in medical school learn to internalize disciplining practices.

These findings reveal that organizing and controlling biomedical knowledge and transmitting that knowledge to medical students necessiate a seniority structure through which teaching physicians become highly powerful and authoritative figures as they possess the knowledge and competence to apply abstract knowledge to each specific case at hand. To become one of them, medical students comply with what medical school, as a totalizing institutional setting, demands from them. In this process, on the one hand, they acquire technical, professional, and social skills needed for practice. On the other hand, the arbitrary nature of biomedical knowledge are controlled, and rules and regulations of biomedical education are maintained. While doing that, the gendered relations through which gendered hierarchies are (re)produced are pervaded in the seniority relations too.

During the time I participated in the public health course at a private university, whose students comprised the majority of my interviewees, I started to hear rumors about how women and queer people criticize the normative content of biomedical knowledge. There were objections about the content and framing of biomedical knowledge. Some interviewees told me that lectures heavily focus on the male body and bodily functions in the context of sexuality and sexual helth. Moreover, the sexual activities are mostly framed within the concept of reproduction. For instance, there is a lack of attention to female orgasm or less attention than they discuss male sexual organs and bodily orgasm. Like the way knowledge about intersex people is shaped by societal expectations and their needs and rights are ignored, women's body and sexuality is ignored as well. Secondly, there were objections about how other healthcare workers perceive men and women interns. Women interviewees told me that they were not seen equal to their male colleagues who are at the same level of the seniority hierarchy. For instance, according to women interviewees, nurses call women interns "tatlım" or "canım" (*honey* or *sweetie*) while they call men interns "Doktor Bey" (*Mr. Doctor* or *Dear Doctor*). The objections about the normative structure of medical knowledge in this university caused some professors to demand a meeting in collaboration with a medical anthropologist and a public health doctor to discuss what was wrong with the long-held knowledge and learning materials for new generation of medical students, what they did wrong to get these objections from medical students, primarily women and LGBTI+s, and of course, why and from where of "outside" social world these "new concerns" were coming. And for the objections against the attitudes of nurses, I learned that the dean of medical school held a meeting with women interns to hear their concerns. Sema told me that the dean restricted the topic with the attitudes of nurses even though she also wanted to discuss the social environment in medical school where women face unequal treatment and gendered

discourses. She had asked the dean whether it was true that surgical teams did not want a woman to join the team. She told me that the dean immediately slid over the question.

As I have discussed earlier, many anthropological studies on science and medicine questioned how the sciences claim not to be constructed but to exist outside the social and cultural world. These studies argue that medical knowledge "can not be abstracted from a set of social relations" (Good, 1994, p. 115). It is, at the same time, social knowledge. Therefore, medical doctors, students, interns, and other healthcare workers are social actors in that complex. Emily Martin (1998) uses a three-part metaphor, that are, are citadels, rhizomes, and string figures to draw "a picture of the natural and medical sciences as complex, in constant, turbulent interaction with many parts of the cultural landscape" (p. 29). Citadels refer to the sciences' claims of no culture, as if they produce knowledge in an isolated realm, and then they command, control, and defense that knowledge. However, Martin argues that the citadel walls are "porous and leaky" (p. 30), and knowledge in the citadel and its production could be linked with processes and events outside. Rhizomes, taken from Deleuze's conceptualization, refer to constant interaction in both ways between sciences and the social world in which the sciences are also embedded. Through this, we can see nonlinear, discontinuous, and complex processes that scientists and nonscientists "are forging ways of acting, being, and thinking in the world" (p. 28). She emphasizes that the progress in science would be part of larger cultural developments, not just mirroring them but not necessarily leading them somewhere either. Progress in science could contribute to the spread of a specific element of a rhizome in another place. Even though just a meeting in one university does not bring a comprehensive and structural change, it shows a glimpse of how contradictions emerge, and hierarchies and their relation to biomedical knowledge which enforce the existing system through the possession of knowledge are questioned occasionally.

In this private university in Istanbul, we see that feminist and queer students try to problematize the way medical professors frame the discourse on the human body, sexuality, and gender, and openly express what they find problematic. In return, some professors ask social scientists to tell them the social and cultural aspects of medical knowledge and the political demands of the new generation of medical students. While there was no mere willingness of professors to go along with the social and political aspects of medical knowledge, I argue that there were possibilities of interaction and affection from the so-called outside world, i.e., feminist and queer movements in Turkey, and feminist studies worldwide. However, we can not belittle the resistance of powerholders and strategies to reproduce the existing hierarchy and power of biomedical knowledge.

While Good's argument about the medical school as an "extraordinary totalizing institutional setting" parallel to Foucault's notion of panopticon-like setting as a disciplinary mechanism in modern societies is partly true for how medical school and training are organized, this research shows that the totalizing characteristics of medical school do not entirely erase contradictions within the biomedicine, the opposition of medical students to social and cultural norms of biomedical knowledge in general and teaching physicians' subjective knowledge in particular, and to the abusive nature of the seniority structure. Exposing both compliances and objections on the seniority structure and hierarchy, the normative discourse of medical knowledge, and their relations with each other demonstrates that the seniority structure organizes and controls every aspect of medical knowledge and practice, including knowledge about gender in science and medicine and gendered social relationships, reproducing the traditional value-system of the society in which it is practiced.

While these aspects of biomedical knowledge hold true for surgical specialties, there are surgery-specific aspects in seniority structure in surgical training, making it stricter than other

medical specialties. In the following section, I will focus on the seniority structure in surgical specialties.

2.3. Surgery, Surgical Training, and Embodied Practice

Surgery is an embodied and hands-on practice. As much as it is medical and scientific, it is also a craft to be mastered. Like non-surgical specialties, surgeons must interpret the signs, symptoms, lab values, and other physical examinations to decide when, in which part of the body, and how a surgical treatment is needed. The difference between surgical and non-surgical specialties is that the central act in surgery happens in a measurable, severely limited period of time (Cassell, 1991, p. 3). While medical care is about processes in non-surgical specialties, surgical specialties are about events. In her ethnographic study in which she deeply engaged with surgeons for an extended period of time, anthropologist Joan Cassell uses the "miracle" metaphor to describe surgery since a successful operation can be described as a "miracle" and rapid results expected in surgery has a miracle-like quality. In the surgical events, i.e., the operation, surgeons must know how to cut and at the same time train their juniors without dangering the health conditions of patients. Cassell states that "the surgical miracle is irreversible; the patient's body will never be the same" (p. 3).

In addition to "miracle-like" quality of surgical events, the arbitrariness of biomedical knowledge is also valid for surgical specialties. Medical students need to learn how to interpret the given data from their seniors. They need to know how to see through the *medical gaze*. Taking the medical profession also as craftsmanship, Richard Sennett shows the difference between an inexperienced medical student and an experienced medical doctor in the following paragraph:

> "The experienced doctor, as one would expect, is a more accurate diagnostician. This is due in large part to the fact that he or she tends to be more open to oddity and

> particularity in patients, whereas the medical student is more likely to be a formalist, working by the book, rather rigidly applying general rules to particular cases. Moreover, the experienced doctor thinks in larger units of time, not just backward to cases in the past but, more interestingly, forward, trying to see into the patient's indeterminate future. The novice, lacking a storehouse of clinical histories, has trouble imagining what might be an individual patient's fate. The experienced doctor focuses on a patient's *becoming* [emphasis added]; raw talent thinks strictly in terms of immediate cause and effect. The craftsman's capacity of prehension is thus elaborated in long-term medical practice." (2008, p. 247).

What is specifically added upon the surgical training is that medical students should practice and learn how to cut and invade the beneath of the body's surface. Therefore, they also need to know how to move with the *medical hands* in addition to the medical gaze. This central aspect of surgery gives senior surgeons/professors the ultimate power to occupy the top position. Not just being at the top position within the surgical seniority structure, surgeons are accepted to be at the top of the prestige hierarchy of medical specialties either.

Surgical practice is a highly charged activity to be mastered. Joan Cassell (1991) identifies five characteristics of being a good surgeon. These are good hands, i.e., technical proficiency, experiential and scientific knowledge, clinical judgment, i.e., the ability to apply general knowledge to the specific case at hand, a good temperament since a person with the wrong temperament might hesitate in emergencies and have difficulty in decision-making processes, and lastly, personal qualities, such as the ability to concentrate for long hours of operation. To train juniors with these technical skills and personal qualities, surgical training does more than teach them how to operate. It also includes socialization processes through which medical students learn how to be team members in the operating room and good colleagues as they acquire a professional identity over time. As Cassell indicates, the technique is necessary but

not adequate. She states that "a gorilla can (theoretically) be taught to operate" (p. 29), but a surgeon is undeniably more than a "hired knife" (p. 12).

The surgery-specific characteristics of the surgical specialties in mind, I asked my interviewees questions regarding seniority structure in surgical training. They explained surgery-specific aspects of the seniority structure and why and how seniority is more strictly enforced in surgical specialties than other medical specialties. Sema (24) told me a famous proverb circulating between medical students, interns, residents, and professors: *Çayda dem, cerrahide kıdem*. It can be translated as "brewedness for tea, seniority for surgery." In Turkey, the degree of brewed-ness of tea determines whether that tea is good or not, depending on the preferences of a person. As it is commonsensical to discuss the brewedness of tea, juxtaposing it with seniority in surgery means that seniority structure in surgery is good and normal to have, even though the "excesses" it might bring can be criticized. It is accepted as the basis of surgical training, and through that proverb, we see that it is normalized in medical education.

Özge (25) is a sixth-year female medical student in an Istanbul private university, expecting to graduate this year. She is preparing for TUS (Medical Specialization Exam) and wants to be in a specialty where she can find more balance between her professional and personal life, meaning that she does not want to choose too much time and energy-consuming specialties. However, she told me that when she entered the medical school, she wanted to be a surgeon like many first-year medical students. She says:

> Surgeons are like bosses. Whatever a senior surgeon says to you, you must act accordingly. Otherwise, you can not find any opportunity to be in an operating room, let alone perform a small task in an operation. There are several surgeons who do not allow one to practice when they do not like the intern. So it is up to them to decide who will be skilled. If you want to pursue a surgical career, you must accept the

> situation. After climbing the seniority ladder, it is then up to you to decide how you behave to *your* juniors.

Berk (24) is a sixth-year medical student at another private university in Istanbul. He has done internships in different surgical subspecialties at the same university and wants to pursue a career in otorhinolaryngology in England. He says that "the hierarchical relations in surgical training is too problematic."

> When you object to something, they automatically say that "surgery can not tolerate any error" and you can not say anything to that. But when there is no emergency, for example, bleeding during the operation, there is no purpose in shouting at juniors and making them nervous in the name of guidance and training. This has nothing to do with the seriousness and the importance of the operation. For instance, they expect a newcomer intern to know everything. But if it is the first operation that the intern has attended, if he/she is holding the light in the wrong way, you can say in a kind and proper way to correct the mistake in an operation running its course, and there is no emergency. They just prefer to be rude.

Berk's example of a mistaken hold of the light for the first time in an operation is significant as one of my interviewees went through this exact incident. Elifnaz (24) is a sixth-year medical student at the same private university. She explained how she felt when she held the devices for the first time in an operation:

> In my first time holding the devices, I was too nervous. I cannot say to my professor that this was my first time. This cannot be my excuse because the patient is lying on the operating table. Their organs are out there. I cannot fail. When you do not make your move in the exact way they want, they start to yell and insult you. I know that nothing is personal. It is just because of too much stress. But I take it personally. I can

not help it. And I become very sorry and feel like I would start crying in front of everyone during the operation.

Her account makes Good (1994)'s argument of medical school as a totalizing institution apparent as her sense of worth is undermined by harsh criticism and insults from professors. Medical school can highly influence self-worth and confidence for medical students since it subjugates medical students to a constant surveillance and discipline and medical students internalize this subjugation to the extent that a mistaken hold of a device can cause severe self-criticism and sense of failure. Elifnaz further told me that she believed in her physical strength to be a surgeon since it is traditionally accepted that surgery requires an enormous physical power and strength to cut and repair human body. In this context, the so-called "physical powerlessness" of women is a common excuse for many to justify why they do not regard women as surgeons or why a woman surgeon is still unintelligible for, with the words of Özge, *the medical bosses*. Elifnaz also explained to me that seeing blood during the procedures or physical difficulties of surgery did not bother her. She does not see herself not being able to do complex technical procedures. However, she states, "The emotional burden in social relations between professors, residents, and nurses makes me anxious and tired." She gave up choosing a surgical subspecialty later in the years of medical school, even though she came to medical school to be a surgeon like many of her peers and told me that she had run away from the classes in the first year to go to operation room and watch.

Daghan (25) is also a sixth-year male medical student at the same university and is currently an internal medicine intern. He wants to specialize in psychiatry and has done his surgical internship in gynecology and obstetrics. He argues that seniority structure is necessary to manage patient care and juniors' training simultaneously. He explained why it is imperative:

> I am not sure whether the seniority structure gives too much power to seniors of all layers, whoever at the top of you. However, there is an odd work pace in surgical departments. These people spend more than half of their lives at the hospital. That is why they need a hierarchical relationship. Otherwise, it might not be clear who is doing what. Surgeons need this most because they spend long hours together in closed environments.

Like Daghan, İlknur (26), a sixth-year medical student in the same private university, described the necessary part of the seniority structure as to everyone can train their juniors from the top layer to the bottom. However, she stated that "this is way too much in surgical departments and open to abuse. They often forget that the person in front of them is also an adult. They yell at their juniors as if they are children. I do not think that this is an enlightening method to train someone."

Their accounts of why surgical training requires a strict seniority structure are effective in understanding how hierarchy is constructed and justified in surgery. In the above different and sometimes conflicting stances of subjects towards this hierarchy, wee see that subjects interpret the strict seniority structure and hierarchy from different angles. They appear to recognize the fundamental convention in traditional surgical culture through which the seniority hierarchy and abusive relations find validation. This convention is driven by the hands-on nature of surgical practice within a constrained operational timeframe. This rationale stems from the understanding that even a minor lapse in this context can yield significant repercussions, thus necessiating a stringent approach. However, even though all subjects understand this aspect of surgical specialties, the ones who problematize the seniority structure think that this justification often opens pathways to abuse and unequal power relations. They argue that constant yelling and insulting have nothing to do with the hardships of surgery or the irreversible character of an operation on human bodies. According to this

convention in surgery and surgical training, the reason why surgical specialties need a more strict hierarchy than non-surgical specialties lies in the difference between what surgical and non-surgical specialties do to care and cure patients and the difference between their working conditions. As senior professors repeatedly use the phrase "Surgery can not tolerate any error" to silence the objections of medical students who problematize yelling, insulting, and other abusive behaviors during surgical training, I looked at the specifics of surgical practice and the culture of surgery in this research.

My interviewees' accounts showed that all of them experienced the abusive behaviors of their seniors to varying degrees. They expressed that surgical specialties had a more strict hierarchy than non-surgical specialties in general. Secondly, while all of them experienced abusive behaviors to varying degrees within surgery itself, the harshness of incidents changed according to the status of the university, whether it was a state or private one. Daghan, Berk, Sema, and Özge observed that the relationship between professors and medical students in a private university must be more cautious and professors had an additional responsibility for their students. This is because while professors in private universities are salaried employees of the university, some of the students who do not have a full-scholarship have a customer-like position. However, this difference between state and private universities results in only relatively less strict hierarchy in private universities. Therefore, I argue that the characteristics of surgery and surgical seniority structure can be generalized for both state and private universities in Istanbul.

So far, I have analyzed how seniority structure and hierarcy are justified through the social convention that surgery cannot tolerate any error and it was an irreversible event taking place in a limited time period, which is highly demanding and stressful. Now, bearing Cassell's (1991) statement that surgical training also includes socialization processes in mind, I want to examine these processes. In her article, *Drilling Surgeons: The Social Lessons of Embodied*

Surgical Learning (2007), Rachel Prentice examines how surgical training remakes the person into a surgeon. Through rituals in the structured environment of the hospital setting and the operating room, such as the process of scrubbing and maintaining sterility, medical students are instilled in discipline and defamiliarized from everyday relations with their bodies and surroundings. They need to gain the right to enter the privileged zone, i.e., the operating room, by learning how to scrub and displaying social skills that convince the attending surgeon/professor of their readiness to approach the patient (p. 539). Prentice further argues that the surgeons she observed measure students' readiness to begin doing simple surgical procedures by a set of social criteria. One of my interviewees' accounts is fruitful to mention here in understanding what a set of social criteria might mean in a specific institution.

Cansu (26), a sixth-year woman medical student at a private university in Istanbul, explained to me what happened when a new resident arrived in general surgery while she was an intern there. This new resident was coming from a small city and was a foreigner for both a metropolitan city and the social environment of the university that Cansu is about to get her degree. Before letting him into the operating room, his senior colleagues, in other words, the experienced residents, wanted to "teach his lesson" (*dersini vermek*) and "force him eat humble pie" (*burnu sürtülmek, kibri kırılmak, kabahatini itiraf edip af dilemek*) to see whether he could meet the challenge to be one of them. As the phrase "forcing to eat humble pie" means being forced to acknowledge one's deficiencies or errors, using this phrase to define the situation reveals that they take for granted that the newcomer will be with mistakes, not fitting in their closed environment. His previous ways of inhabiting the world, even the medical world, are foreign to them. Not knowing the social and institutional codes of conduct in that university and everyday relations, the newcomer is expected to be clumsy, unskillful, or not doing things exactly the way they are required in this specific institution. And this not knowing the social codes means more than learning them. Firstly, he has to put aside what he

got used to for them to "remake" that person into a surgeon. According to Cansu's witnessing, they constantly humiliated his actions and made jokes about him publicly. For instance, she told me that even if he perfectly dressed a wound, they did not like it and asked him to do again, without considering the fact that this act was also harmful to the patient whose wound was repeatedly played by them. In this context, what a set of social criteria might include is open-ended. Several medical students complain about how the attitudes of seniors in the name of maintaining the social criterias of surgery can go wrong within the strict seniority structure as medical students are generally reluctant to object to the wrongdoings of their seniors.

Seniority structure in surgery might appear impartial, simply based on disciplining medical students regardless of gender and remaking them into surgeons. However, the term *medical boss*[6] and the means of transforming a junior into a surgeon are gendered. Moreover, during the process of remaking, everyone might act as if he/she is the medical boss of his/her one-layer low subordinate. It is well-known that women are under-represented in surgery worldwide (Bleakley, 2013). In Turkey, the under-representation of women in surgical departments is at extreme levels. Kuzuca and Arda (2010)'s study about gender discrimination in medicine in Turkey examines the specialty choices of women quantitatively and qualitatively. In this study, we see that the proportions of women's representation in surgical departments range from 0,7% (urology) to 21,5% (pediatric surgery) (p. 5). The lowest number of women are, respectively, in urology, orthopedics and traumatology, neurosurgery, and general surgery (each is under 10%). It is important to note that urology, orthopedics and traumatology, and general surgery are the surgical specialties that both men and women interviewees highly complained about mobbing, harassment, and abusive hierarchical relations, and according to them, these are the three departments that have the most strict

[6] Early classic works on medical education, *The Student-Physician* (Merton et al., 1957) and *Boys in White* (Becker et al., 1961) described the ways in which professional behaviors were acquired through masculine terms and identified the process of becoming a medical professional as becoming a 'medical man.'

seniority structure in medical schools. In this hierarchy, *surgical bosses* are mostly men and decide which intern will practice or which one will be his favorite junior during the process.

These surgical bosses and the masculine culture of surgery have been a subject of inquiry for those who studied the social and cultural aspects of surgery. The increase in the number of women medical students has sparked an interest in the sociology of medical education to discuss the future careers of women medical professionals and the future of medical practice itself. Even though the number of women in medical school constitutes nearly half of the student population in recent years in Turkey and Western countries, the future of the medical profession and practice can not be predicted as if a change will come parallel to numeric increases.

To indicate the increase of women in medical profession, the term *feminization* started to prevail in the studies on gender in medical education and profession in the early 2000s. Having reviewed discourses in these studies and media channels, Elianne Riska (2008) argues that the discourse on feminization represents the organization of medicine as gender-neutral, and it is women as medical professionals who bring gender to an otherwise gender-neutral practice (p. 8). These studies either argue that women will bring gender-essential characteristics to medical practice, which is hoped to be good for a holistic medical approach that composes of not only reductionist technical treatments but also care and nurturing of patients, or they argue that the medical profession will be deprofessionalized as the medical work will be "womanized." However, Riska states that "these prophecies do not take into account the vertical and horizontal gender segregation within the profession that serves as structural barriers for any automatic linear mobility in the organization of medicine" (p. 11). Moreover, discourses on expected changes attributed to the so-called gender-specific characteristics of women homogenize women as a static social category and, more

importantly, confirm the traditional attributes of men by essentializing the characteristics of both genders (p. 13).

In contrast to these early studies, the later studies that do not take a substantial change in medical practice parallel to the increase in the number of women in medical education and profession for granted focus on two questions: why do women students choose different specialties and why are there so few women in top academic positions? The first question links to the horizontal gender segregation of medical practice, while the second one is related to the vertical gender segregation (Riska, 2009, p. 90). As the accounts of my interviewees showed, women wanted to specialize in surgery when they first entered medical school as much as men. However, why are there so few women medical practitioners in surgery, as Kuzuca and Arda (2010)'s study indicated?

According to Riska (2009), there are three major sociological explanations for understanding the specialty choices of medical students and the segregation of women within the medical practice: socialization theory and related sex-role models, structural barriers, and embedded approach. In socialization theory, it is argued that gender socialization influences the specialty choices of women and men differently. It focuses on individual traits and preferences in medicine. It presents women giving more importance to expectations of work-life balance as they are expected to give up on their careers to make a family. While this theoretical approach essentializes gender as an attribute remaining unchanged, it also ignores cultural and structural barriers women face.

The second sociological explanation, structural barriers, criticizes this individualistic and essentialist socialization theory and highlights the structural and cultural obstacles that hinder women from achieving equal access to male-dominated specialties. It argues that these barriers, rooted in societal structures and cultural norms, impede women's progress in these

fields. Riska gives an example of structural barriers, such as the lack of mentors for women who can provide informal socialization, which is one of the fundamental parts of medical education to encourage women for medical specialties where they are underrepresented. Elaborating on the structural barriers approach, Riska offers the embedded approach. That way, she enriches the structural barriers approach without falling into conceptualizing women as passive recipients of societal structures. If we shift the perspective to gendered processes and gendered practices of power, she argues, we can see "various voices and strategies as women are not a homogeneous group, all-embracing or refusing traditional gender roles" (Riska, 2001, p. 7).

When I asked how interns overcome the challenges of the disciplining practices of seniors, Sema (24) asserted that these practices differ depending on the gender of a medical student. Practices of disciplining women students are full of prejudices against women:

> As a matter of fact, both women and men can hardly endure the harsh conditions within the strict hierarchy of surgical training. But seniors do not aim to kick out male juniors. They just want them to be tougher because being a surgeon requires being tough. On the other hand, when the resident is a woman, they prejudicially act worse to her. They think that women are so much more sensitive than men. Therefore, they must more harshly force her to be tough so she can overcome her sensitivity or leave the department. Women are expected to leave sooner than men. Then they are harsher than ever. The sooner, the better, they think.

In the light of criticism against gender socialization theory which focuses on individual trais and preferences, I asked my interviewees whether they prioritize raising children in the future, and if they do, does this affect their specialty choices? I also asked whether they find contradictions between personal and professional life as women. Their accounts show that

they do not confine themselves to what traditional gender roles expected from them. Eda (25) is a sixth-year medical student at a private university in Istanbul. She had done her internships in surgical departments, but she does not want to be a surgeon. She wants to specialize in internal medicine abroad:

> I do not have a plan to give birth in the future, at least for now. I did not choose my specialty preference based on a future family plan. When you become involved in surgical training, you see an inhumane working environment and what awaits you there. You know the situation of experienced people and say that I do not want to be in such conditions. Life is too short for that.

Selma (25), a sixth-year medical student at the same university, also told me that she did not think about whether she would have a child in the future. She stated that her not choosing surgery is not based on the assumed future responsibility of giving birth, but she considers her physical comfort, which is not possible in surgical specialties. To find comfort, she wants to specialize in dermatology. However, as much as surgery is considered to be a male profession, dermatology is seen as favorable to women. When her friends, colleagues, and seniors get the information that she will choose dermatology, they immediately celebrate her and say, "You are a woman, so it is a good choice. Congrats!" She further explained to me that she feels uncomfortable when people reduce her decision to being merely a woman, even though she has other thoughts in her mind:

> They put me in the box of gender stereotypes and then congrats me as I seem to get along with that. They can not think of my decision out of the box of being a woman. And because of that, I sometimes feel guilty about my decision. I question whether I can not do more than what being a woman provides to me.

Women might want to give birth or not. While non-heterosexual relationships are deemed invisible and taken to be out of context in institutions and broader societal relations, for traditional heterosexual family building, women seem to be alone. Discussions about work-family life imbalances focus on whether women will choose to have a family and give birth as if they do all these by themselves. Professors do not ask their male medical students whether they will raise a child and prioritize that over their professional life. Yet, they advise women to choose "favorable" medical specialties to raise their children easily.

Another account related to potential work-life imbalances projected on women is significant to mention here. Hülya (26) is a sixth-year medical student at a state university in Istanbul, and she wants to specialize in gynecology and obstetrics. When we discussed why seniors do not want a woman resident in surgery, she explained the issue from the fact that women are the ones who get pregnant, not men:

> There are too many on-call shifts in surgery. Getting pregnant means that you will be out of on-call lists and have a maternity leave then. That directly affects how many more night shifts your colleagues will have instead of you when you get pregnant. I think this is unjust. What about gender equality while your male colleagues are on night shifts because you decided to have a child?

When I raised the issue of the lack of structural arrangements that can provide sustainable working conditions for both men and women, such as parental leave for both gender and the problematic social norm that accepts women as primary caregivers, she agreed to me. However, she concluded that this is still absurd and unfair in the existing conditions and added, "In the end, this is not a holiday camp."

My interviewees' accounts also showed that subjects took different stances towards gendered discourses and practices rather than being socialized the same as a group of women. Both Eda

and Selma claimed that their specialty choices are not based on the appropriateness of a certain specialty for women despite others congratulating their decisions as confining to gender roles. Conversely, Hülya blamed women for getting pregnant and interpreted the lack of structural arrangements sensitive to gender equality as an individual problem of women rather than a social and cultural problem.

To understand the gendered culture of specialties and the asymmetrical location of women physicians in lower-status medical specialties, Susan Hinze (1999) asks physicians themselves how they construct the prestige hierarchy in their minds. Then, she argues that "medicine, independent of sex or gender as an individual category, is an institution demarcated by bodies, both masculine and feminine. The bodies, whether female or male, that occupy the highest prestige specialty are described as macho, action-oriented, physical, and technologically sophisticated. The bodies that occupy the lower prestige specialties are described as passive, less physical, and affective" (p. 218). That is why surgery occupies the top of the prestige hierarchy. Moreover, a woman interviewee of her claims that she had enlarged "balls" psychologically as surgery requires "balls," in other words, courage, physical power, and action-orientedness. Moreover, Hinze argues that "active hands" repeatedly mentioned by interviewees refer back to the Western dualism of male activity and female passivity. Therefore, independent of being a woman or man in surgical training, you must be a surgical hero with active hands and balls. In addition to that, Cassell (1991) defines surgical temperament as incorporating characteristics that are traditionally attributed to men: "arrogance, aggressiveness, courage, and the ability to make split-second decisions in the face of life-threatening risks" (p. 18).

The experiences of my interviewees demonstrate that seniors justify the strict hierarchical relations in surgical training through the statement that *surgery can not tolerate any error*. However, within and beyond the operating room, this justification normalizes abusive

behaviors through which medical students feel uncomfortable, and this results in the fact that most of the women medical students give up on choosing surgical specialties for their career advancements. This is related to the gendered nature of the seniority structure in which gender discrimination and stereotypical images of women are normalized and used as part of discipline in surgical training. Gender-based discrimination and the everyday circulation of gendered discourses are the delineative characteristics of women's experiences in surgical training. Moreover, the worldwide image of surgeons as arrogant, aggressive, and active male figures, in other words, *surgical male bosses*, reproduces and enforces the strict seniority structure and gendered discourses and practices in surgical training in Turkey. And this makes the seniority structure itself gendered from the beginning.

2.4. "Call Your Seniors Brother/Sister!": Respect For Experience

In this section, I will focus on a compulsory discursive practice of showing respect for seniors. There is a widespread practice to call your senior *abi/abla* (brother/sister) regardless of the exact age of the person in medical schools in Turkey. I will specifically focus on this discursive act because my interviewees repeatedly dwelt on it. Secondly, calling your senior *abi/abla* is specific to Turkey, not just in medical school but in other educational settings either, therefore, it has social and cultural connotations in Turkey's context.

Cassell (1991) analyzes the process of scrubbing as a ritual. Scrubbing is central to surgery. She demonstrates that surgeons she observed substitute the term for operating itself. When they helped operate a case, they would say they "scrubbed" on that case or when they want to assist in an operation, they ask "May I scrub in?" (p. 46). She further observes that scrubbing as a ritual have potential to alleviate anxiety, which is highly related to the existence of an irreducible element of uncertainty in surgical operations:

> An element of uncertainty, of mystery, is always present in surgery. Although the statistical odds for particular procedures performed on particular diseases have been calculated, these probabilities aggregate operations, diseases, patients, and surgeons, as though each performance of a particular operation resembled the next; each case of a particular disease were identical to another; each patient, physiologically, biologically, and personally equivalent to the patient in the next bed; and each surgeon interchangable with any of his colleagues. Because none is equivalent -*not even the same procedure performed by the same surgeon at two different times in the same day*- the statistics can not predict what will occur on a specific occasion. In a probabilistic universe, the surgeon can not be certain that even a comparatively routine procedure will not "go bad" (pp. 47-48).

Cassell contends that the anxiety, along with the resulting emphasis on scrubbing ritual that might lack solid scientific evidence, "like spending ten minutes instead of two on scrubbing," imbue certain procedures with a mystical aura that many surgeons strongly advocate for (p. 48). As proper scrubbing is a first step to be allowed to enter the operating room in the process of becoming surgeon, it is also one of the disciplinary mechanisms of remaking a person into a surgeon.

One moment that one of my interviewees questioned a professor's act demonstrates the disciplinary part of scrubbing rather than just being a sterility concern. Elifnaz (24) explained that professors wanted all male members of surgical training, from interns to attending surgeons, to be completely clean-shaven. She told me that a professor slapped a male intern in the face during the operation when he had very little beard that was barely seen beneath the face mask. She was shocked as to how this professor could not think of maintaining sterility during an operation just because an intern did not follow the rule. In another incident, one of her friends told her that a male resident was kicked out of the operating room -the professor

was swearing him to get out- because of the same reason. The moments of disciplinary crisis show that many procedures have a ritualistic and disciplinary aim to shape and control juniors' behaviors and surgical space. Having very little beard might be less damaging to sterility than touching an already sterilized person that the slap act caused. Moreover, taking being clean-shaven too seriously is about dress code rules that medical students must obey as this moment of crisis reveals that most of the acts have more deep-down meanings than it is claimed on the surface. For this reason, I want to turn to analyze the discursive act of calling seniors abi/abla to comprehend deep-seated meanings of the act and what it encourages and discourages in the context of surgical training.

Different than English-speaking world, the terms *abi* (brother) and *abla* (sister) directly connotates to older brother and sister. Therefore, calling someone *abi/abla* automatically puts them into an age hierarchy. In medical school context, while it is assumed that one person at an older cohort in medical school will probably be older than the newcomers, calling someone *abi* or *abla* is not directly related to his/her age but the year of experience and associated ranking within the profession. Seniors, mostly professor surgeons, enforce juniors at each level of seniority hierarchy to call each other *abi* and *abla*. It is a discursive expression of master-apprentice relationship in medical education.

As the opening quote from Hippocrates' Oath shows, medical education is historically constructed through master-apprentice relationship where the oath expects physicians to treat their mentors/masters as if they were their own fathers and treat students/apprentices as if they were their children, assuming a sense of familial obligation for their well-being (p. 69). This relationship enables the training of apprentices, allowing them to acquire and master their understanding of medical knowledge and practice. The experienced masters impart their expertise to the inexperienced apprentices/students/sons, helping them to gain proficiency in medical profession. The hierarchical system in medical education comes from this tradition.

In that context, professors/masters/fathers obligate juniors to call their seniors brother/sister, requiring them to show respect discursively in everyday relations. My interviewees explained that they called residents and attending surgeons *abi/abla* (brother/sister) but professors were still called "professor" or "hocam"[7] not brother or sister. The father figure makes the distinction that they are the father and at the top of the hierarchy. One of the residents who became attending surgeon next year called juniors that he was no more a brother but had to be called "hocam" now. The hierarchy within the same ranking is also marked as less experienced residents call more experienced residents and attending surgeons brother/sister, depending on the years of experience.

Fabio Vicini (2013), in his ethnographic study of Gulen community in Turkey, explains the pedogogical modality of being a *abi* that shapes the everyday social relationships. While the medical school is a secular context, resemblances of using a similar pedagogical method is significant to emphasize here. Where younger students who stay in Gulen community's dorm rooms learn ethical-moral dispositions that lead them to live accordingly with a definite religious life conduct, juniors in medical school also learn formal and informal instructions of their brothers and sisters which includes ethical-moral dispositions of medical school. Calling someone brother/sister and establishing good rapport highlights "a delicate balance between distance and proximity that was continuously played out" (p. 386) between juniors and seniors. Vicini argues that "the former's authority and related role as a guide to the latter was recognized and marked by the respectful expression, which is also commonly used in daily interactions in Turkey, while, in this case, it demarcates a distance in status and experience between younger and older ones, which implies respect and will to follow the suggestions and indications" of *abi/abla* by the juniors (p. 386). From the side of abi/abla, willingness to

[7] "Hoca" is the master in Turkish. "Hocam" can be translated as "my master."

assume responsibility and take care of juniors is significant to give legitimacy and efficacy to their pedagogical and everyday social interventions (p. 386). In this relationship, they are neither too friendly nor too formal. When I asked my interviewees how they give meaning to the concept of *abi/abla*, in-betwenness of distance and proximity is highlighted and subjects again take different stances towards this practice.

Elifnaz (24) emphasizes the blurry character of the concept of *abi/abla*:

> In the first days of internship, we got pretty excited to start calling our seniors abi/abla as a privileged position over pre-clinical students. Because while you call *hocam* in a formal manner to all your seniors, you suddenly become close, a sign of sincerity. We spend time day and night, so it is nice to use a more friendly word. However, I am aware that it changes the way they tolerate you or you tolerate their sometimes aggressive behaviors. They yell at you more easily and then make peace easily because they say "I am your brother! Why did you get so upset?"[8]

Duygu (24), a female public health intern at a private university in Istanbul, recalled an incident when an intern was older than a resident. When thirty-year old intern call out to the resident by name, a professor who heard that got angry and reminded the intern that this was about respect to your senior, not an age issue. And Burak (25), an intern in public health at a state university in Istanbul, witnessed that a resident embarrassedly apologized from an attending surgeon because he accidentally called out to the attending surgeon by his name.

The difference between experiences of female and male students regarding the concept of *abi/abla* is fruitful to emphasize here to show gendered character of building good rapport

[8] "*Ben senin abinim! Neden kızdın ki*?"

through the concept of *abi/abla* in surgical training in particular and medical school in general.

Nurhan (26) is a female practitioner in emergency department at a state university for now and she has recently graduated from the same university. She ambitiously wants to pursue a surgical career. However, sexist incidents that discriminate women she herself experienced, mobbing she has witnessed, and socioeconomic situation in Turkey led her to decide pursuing a surgical career abroad. She witnessed that an experienced male resident came to one of her female friend and said: "Look honey, we like you a lot here, but do not come here if you plan to write this residency down after TUS. You probably will quit if you come." Nurhan told me that her friend could not recover herself emotionally for one week after this conversation.

Büşra (25) is also a female intern at a state university in Istanbul. She thinks that calling someone *abi/abla* should not be a requirement. If she feels closeness to someone, she wants to decide by herself what to say. She argues that calling *abi/abla* does not necessarily bring closeness or friendliness, conversely, strict rules and unequal relations between people in daily interaction are maintained that way. Another female student, who agrees with Büşra's statements, additionally claims that calling *abi/abla* in the name of the so-called closeness actually brings sexist jokes and humors. When a female student gets uncomfortable with sexist jokes in daily interactions, "brothers" immediately say in return that it was "just a joke" and "I am your brother."

It is a common practice in medical school that your *abi* might send you to the market to buy him cigarettes. Nurhan (26) explained to me that women might get resentful when seniors demand these kind of stuff. However, she claims that men are generally okay with that because male interns think that they can go to buy cigarettes and they smoke together with

that senior and start a conversation during smoking, allowing them to turn this into an advantage to build a good relationship, moreover, a close friendship.

As an example to Nurhan's claim, Daghan (25) explained to me his relationship with seniors, namely, brothers:

> Residents in our hospital act like friends to us. It is not like "I am your senior! Do what I say!" but we share our work according to our abilities and position in the ranking. But I know that people in surgery are generally impolite. I mean, they do trash-talk because surgical specialties are composed of men. I do trash-talk with them too. When a female intern or resident arrives, they immediately become polite to them though.

However, after a second, he says "this is partly related to the fact that we have already become friends. I have met them before during coffe breaks or smoking. They can treat me as sincerely as they wish." He does not say these words in a negative way, rather he interprets their behaviors and his response as a way of socialization. When I ask him why women could not build this kind of relationship, he says "there is no reason for women not to build a friendship with seniors. Whoever wishes that, they can come and join the conversation. If you show them that you do your job in a good way, they are ready to be close." His account shows that this discursive practice eases men interns' attempts of socialization and friendship building during surgical training. Moreover, it is important to highlight that what Daghan means by trash-talk is sexist jokes as an integral part of men's daily socialization. And this is also one of the reasons why women do not see this kind of relationship in positive terms and an opportunity to get close with seniors at each level of the seniority hierarchy. Instead, this discursive act is another way of making women's bodies and sexualities an object of ridicule, resulting in the exclusion of women from close ties in surgical community.

Ayça (25), a sixth-year female intern who wants to specialize in genetics, has about to get her degree from the same private university with Daghan. She told me that there are so few women in surgical specialties and she does not see herself communicating well with male seniors as she thinks that she is not interested in their conversation topics. She says that she feels comfortable when more women are around, for instance, in internal medicine in which she is an intern now. Her account is effective in understanding the importance of mentor or role models in medical education. Since there is less or no women in surgical specialties, some female students do not feel that they can build friendly relationships in surgical specialties. Ayça added that there was one female general surgeon in their university hospital and when she found the opportunity to work with her once, she felt "incredibly at ease."

To conclude this section, as women's experiences demonstrated, hierarchical relations and practices to strengthen and sustain the seniority structure put female students, interns, and residents into a disadvantageous position compared to men. Calling seniors *abi/abla* does not bring an immediate friendly relationship to everyone. It carries practices of exclusion. Women, more frequently than men, can not find a "friendly" *abi/abla*. Rather the concept of *abi/abla* provides an opportunity to male juniors in daily socialization processes. In other words, gendered discourses and practices embedded in their social milieu supported by seniority hierarchy and associated concept *abi/abla* creates a male privilege.

2.5. Conclusion

In this chapter, I examined the seniority structure and hierarchy in medical school in general and surgical training in particular. This attempt was to understand gender relations in surgical training. As women are underrepresented in surgical specialties and face gendered hardships and exclusions there, analyzing social conventions, norms, and habits enforced and (re)produced by the seniortiy structure in surgical specialties helps us comprehend the specifics of gender relations. I argue that the existence and maintenance of the seniority

structure are indispensable to the construction of gendered discourses and practices, which makes the seniority structure itself gendered from the beginning.

In *Medical Knowledge* section, I focused on the relation between the seniority structure and the nature of medical knowledge. I analyzed how embedded uncertainties and ambiguities in medical knowledge system were controlled and reduced by the seniority structure. That way, transforming a seemingly unified and cohesive knowledge system in biomedicine to medical students also becomes possible. More importantly for this research, we saw that controlling and reducing the uncertainties and ambiguities meant maintaining gendered and sexist social norms both in medical school and broader society.

Then, in *Surgery, Surgical Training, and Embodied Practice* section, I focused on surgery-specific aspects of the seniority structure and hierarchy. It was revealed that the seniority structure was more strictly enforced in surgical training. This was highly related to the nature of surgical specialties. The experiences of my interviewees demonstrated that seniors justified the strict hierarchical relations in surgical training through the statement that *surgery can not tolerate any error.* As surgical practice and care is mostly about events in limited timeframe of operations, the pressure it put on the surgical practitioners at each level of the seniority hierarchy resulted in justifying abusive and aggressive behaviors coming from seniors to juniors. In this context, gender-based discrimination and the everyday circulation of gendered discourses became the delineative characteristics of women's experiences in addition to general bad attitudes of seniors against all juniors.

Lastly, in *"Call Your Seniors Brother/Sister!": Respect For Experience* section, I analyzed the compulsory discursive practice of showing respect for seniors by calling them brother/sister. It is a discursive expression of master-apprentice relationship in medical education. While it was a disciplinary practice for all juniors, it bore an additional burden for women in medical school. Against the expectation that this was to build good rapport with seniors, which mostly

worked out for men interns, women's experiences showed that calling seniors *abi/abla* did not bring an immediate friendly relationship to everyone. Instead, it carried practices of exclusion and created a male privilege in surgical training.

CHAPTER 3: EVERYDAY GENDERED INTERACTIONS IN SURGICAL TRAINING

3.1. Introduction

Feminist analyses of gender discrimination in workplaces and in the medical profession have contributed to our understanding of women's position in the labor force in general and the medical profession in particular, in terms of vertical and horizontal segregation, gendered pay gaps, not being represented at top positions in the job hierarchies, and more importantly, everyday gender-based discriminative practices that women face (Witz, 1990; Reskin and Roos, 1990; Davies, 1996; Riska, 2001; Hinze, 2004; Adams, 2010). The feminist critique of the appointed male gender for many authority figures in varying jobs showed that the supposedly neutral categories and descriptions were understood to be men's natural places to be occupied by men, excluding others (Hinze, 1999; Cassell, 2000).

Building on these feminist efforts to understand unequal gender relations in the medical profession, in this chapter, I will focus on everyday interactions between interns, residents, attending surgeons, and professors in hospitals during surgical training. The importance of everyday relations is that analyzing them will help us understand new and subtler ways of gendered norms in medical school and surgical training and gendered hierarchies of power embedded in the seniority structure. Moreover, understanding daily interactions can uncover their dialectical relationship with broader institutional and cultural ways of conduct that reproduce and maintain the existing exclusionary and unequal social milieu of surgical training. As I have focused on the seniority structure and hierarchy in surgical training in the previous chapter, now analyzing what kind of gendered everyday relations the seniority structure creates, (dis)allows, contains, or absorbs will help us have an enriched understanding of gendered power relations in surgical training and why women are underrepresented in surgical specialties.

Before delving into the everyday gendered relations, I want to contextualize women's increasing but limited presence in surgical specialties in Turkey. Since 1987, the Student Selection and Placement Center (ÖSYM) has started to apply the Medical Specialization Examination (TUS) in Turkey. Before that, newly graduated medical students had to apply directly to the medical specialty and the institution that they were interested. Several older-generation women physicians and surgeons recount stories of not being wanted in some schools and branches just because they were women. They were not accepted by the selection committees, primarily composed of men. Thus, TUS has partially excluded the preferences of authorities/selection committess that selected candidates for specialization in medicine by centralizing the admission process through a test based on multiple choice questions in exam centers and then scoring them anonymously. Even though the centralization and entrance to specialties through an examination bear other unequal and exclusionary dynamics, such as the stressful preparation process for medical students and high-priced exam books and education centers, it gave more opportunities for women who wanted to pursue a career where they were previously not wanted.

After the initiation of TUS, we have seen an increase in the number of female medical students in surgical specialties, and their number continues to increase yearly (Kuzuca and Arda, 2010). Therefore, sexist practices, such as not accepting women in surgical departments and banning them from specific fields, do not hold the most significant influence over women's experiences in surgical departments today. However, this official abolishment of discriminatory practices in medical education does not erase everyday patterns of discrimination and exclusion in surgical workplaces. It is well known that some female physicians who started their specialization training in surgical departments could not complete the training they were entitled to with academic success (Kuzuca and Arda, 2010).

According to Kuzuca and Arda's (2010) findings, women are still reluctant to pursue a career in surgical specialties in Turkey because they think the working conditions in these branches are more severe or there are implicit or open discriminatory attitudes towards them. Building upon Kuzuca and Arda's findings, my research exposes the persisting gendered structures, practices, and discourses that shape the experiences and subjectivities of medical students and affect their decisions in specialty choices.

According to Iris Marion Young (2005), structures denote the merging of established rules and interactive patterns within institutions, the utilization of resources, and physical arrangements. These elements form the historical givens in relation to which individuals act and make decisions. They are generally consistent over time. Additionally, structures encompass the broader social outcomes that arise from the combination of numerous individual actions within specific institutional frameworks. Even though these collective effects often do not point at a particular individual or group as responsible for the social outcomes, inequalities, or injustices, macro structures still depend on micro-level interactions for their production and reproduction. Young further argues that a structural account provides an approach to comprehending unequal opportunities, oppression, and domination that does not solely focus on identifying specific individuals responsible for these issues. Instead, it acknowledges that most individuals contribute, to varying degrees, to the production of gender structures and hierarchies. In another article about oppression, Young (1990) highlights that oppression refers to the vast injustices some groups suffer as a result of "often unconscious assumptions and reactions of well-meaning people in *ordinary interactions*, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms -in short, *the normal processes of everyday life*" (p. 41). While the conscious actions of individuals daily contribute to sustaining and perpetuating oppression, those people are usually simply doing their jobs or living their lives and do not perceive themselves as actively enforcing oppressive

systems (p. 42). Therefore, focusing on this "doing their jobs" and "living their lives" through everyday relations will reveal gendered assumptions, norms, and practices which contribute to the gender structure of surgical training. As Hinze (2004) highlights, research based on the experiences of everyday life exposes the hidden and symbolic aspects of gender while increasing awareness of the relationships that influence and control our daily existence (p. 121). In subsequent pages, I will look at the seemingly inclusive but subtler ways of (re)production of gendered hierarchies, practices, and discourses, which affect women's career choices and existence in surgical specialties.

3.2. Women as "Flowers" in the Context of Survival and Challenge

At the beginning of my research, I went to a public health lecture at a private university in Istanbul to introduce myself and ask medical students whether we could talk about their specialty choices, gendered experiences, and hardships that they face in medical school and during their internship in surgical departments. The lecturer introduced me as a "feminist" "social sciences" student to the interns in the class. At first, I felt some students were uncomfortable seeing a feminist *again*. The predominant atmosphere in the class was "Why do we always have to talk about feminism and sexism against women?" or "This topic? Again?" because one the interns expressed that we always talked about women, gender, and sexism and this was enough for him. Moreover, two men's facial expressions seemed bored to me. This reactionary position was repeatedly recalled by women interns as well. For instance, Sema (24) said:

> When women in medical school complain about injustices they face, or when we demand equal treatment from our seniors, men think that we want to take everything they have away from them as if we do not want to be equal but above them in life.

The lecturer mentioned that the administration decided to initiate a gender equality program in collaboration with an international institution. When we started a discussion about gender equality policies in universities, one of the men interns in the class said that there were well-mannered gender equality policies in their university, and women and men were “totally” equal in their institution. He said, “If you face any problem regarding that, this probably will be about one sexist man,” who is taken to be exceptional. Moreover, two men interns said professors were harsher on male interns than women. When I asked why women did not choose surgery then, they told me, "If they want, everyone is welcome.” However, Elifnaz (24) interrupted them and said that women and queer students still face different faces of sexism in their everyday life in medical school, and surgical departments are worse than non-surgical ones. She argued that men usually did not understand what kinds of behaviors were sexist or degrading for women or why women felt they were not wanted in certain medical specialties. She claimed that women were socially and institutionally forced not to choose certain branches for specialization training. After this conversation in the class, I realized that some of the men interns feel defensive against women’s concerns and feminist agendas that are brought to them in their everyday interactions. I asked the class whether they wanted to share their experiences with me. I also asked men interns who expressed their concerns about “too much attention to gender issues” whether they would share why they felt “overwhelmed” by feminist concerns. A man intern did not want to make an interview with me and nervously said, “I do not mess with anyone. I just come and study hard. I am a sportsman. I just do sports and do not get involved with these kinds of stuff.” He added, “In medical school, you just survive, whether you are a woman or man.” His mood was like I would find something to blame him if I had the opportunity to talk with him. With his words, he was nothing to do with women’s problems. Later, during the interviews, I understood that some men -interns, residents, and seniors- were bothered by feminist demands within the medical school, and

they cautiously acted and approached women in daily interactions not to get objections or any criticism regarding their sexist attitudes. For instance, two women interns in the class told me that some men watch their steps not to use sexist slang or jokes while women are around for fear that they might be publicly canceled. What they meant by "public cancelation" is being publicly criticized and labeled as misogynist, reactionist, and conservative. However, it is essential to emphasize that their cautious actions are mostly not based on taking the degrading quality of their sexist acts or the consequences of the hostile working environment to women and LGBTI+s into consideration. Instead, it is one of the ways through which they protect the close knits between men and masculine socialization practices *behind the doors* this time.

The majority of women interns told that they did not personally experience "extreme" cases of sexual harassment. However, the rigid hierarchy of authority and power in surgical training shapes and determines the proper ways of everyday conduct between juniors and seniors, which is deeply gendered. In this context, sexual harassment and mobbing are still not exceptional but embedded in the medical school tradition. The force behind the less hostile working environment is that university and hospital policies on gender equality and circulating objections of women and LGBTI+s medical students are now more echoed in the corridors of medical schools and hospitals in Istanbul where I conducted my research. For that matter, the historical accounts of gender discrimination and sexism change in today's surgical training in Istanbul, nevertheless persisting and reproducing.

Firstly, my interviewees distinguished good and bad-tempered seniors regarding their attitudes towards juniors. The older generation of surgeons, i.e., senior professors, are relatively stricter and more arrogant towards subordinates. The accounts of harsh treatment of both men and women are about these arrogant professors' behaviors. Sema (24)'s previous account[9] of

[9] p. 36

professors trying to kick out women interns and behaving prejudicially against them is crucial here. When I asked who were these professors she was talking about, Sema told me that they were mostly older authoritative male figures of surgery, in other words, senior male professors. Rumors and gossip circulate in medical students' social milieu about which professor openly expresses his reluctance to work with a woman intern or resident or which professor encourages his team to annoy a newcomer woman resident joining their team to force her to drop out of the residency. These are shared accounts of my interviewees about these male figures. These male figures try to maintain the traditional gender structure. Elifnaz (24) described these authoritative male figures as "patriarchs of the medical school." She further said:

> I generally do not get along well with these patriarchs. Other than the minimum required time that I have to be in contact with these patriarchs, such as during lectures, operations, or compulsory school and hospital events, I do not make extra effort to be close to them. I prefer communicating with professors whom people often see as more "feminine." Even though this ascription of "femininity" to the professors I like is not openly expressed, there is a hidden agreement that they are less masculine and, consequently more feminine than the patriarchs. We call the patriarchs "malign."[10] Malign means ill-natured human cells. Malign cells are harmful and dangerous to the human body. So these professors are harmful to our lives in medical school.

Like Elifnaz, Eda (25) finds the attitudes of senior male professors problematic. She claims that senior male professors often put sexist jokes and arguments into words. Even if they do not constantly joke about women, their presence encourages juniors of his team to act sexist and arrogant towards women interns and residents. Eda argues that this situation arises from

[10] Elifnaz directly used the English word "malign" while we were speaking in Turkish. I asked her how she translates this word in Turkish. She sad "kötücül" and "kötü huylu."

the fact that these senior male professors occupy the most powerful position in medical school. Embracing the differentiated ascriptions of masculinity and feminity to certain types of seniors, these "patriarchs" of medical school describe themselves as "not quite well in terms of communication skills," considering communication skills traditionally assigned to women. Selma (25) said that one of the "tough" and "masculine" male professors had told her that he had chosen surgery because he did not like communicating with people in social life:

> He told me and my close female friend that he had chosen surgery because surgical specialties did not require communication skills, which he believes, is a suitable job for a man. According to him, a surgeon is only required to cut and repair a patient's body. The communication part can be left to internists, pediatrists, dermatologists, etc. He further said, "You two are beautiful and sweet women. You speak with other people kindly. I believe that you might be successful dermatologists or pediatrists. These specialties already fit well with women. And these are the specialties in which you can keep in touch with your patients."

The established social expectations in medical school assign gendered characteristics to medical specialties. The idea that having good communication skills is related to women's so-called caring and nurturing capacities, a quality socially assigned to women, leads this professor to advise women interns to choose specialties where he believes women can flourish and improve their supposed "natural" skills. On the contrary, the fact that men are expected not to like communication, caring, and nurturing orient them to their "natural" occupation, that is surgery. Men in surgery will not be required to build social relationships with their patients, who will be unconscious during most of the doctor-patient interaction, and surgical professors will primarily be interested in the patient's body or parts of the body. That way, the professor normalizes and naturalizes his position in surgical departments. He is the natural occupant, the owner of the surgical specialties.

Before moving on to my interwiewees' accounts of good-tempered surgeons, I would like to focus on how these patriarchs interact with juniors, differing according to juniors' gender. At first, regardless of juniors' gender, bad-tempered male senior professors often act as authoritative figures who can be a pain in the neck for their subordinates. In her ethnography of women surgeons, Cassell (2000) also makes a definition of this type of surgeon as "a temperamental surgeon can complicate the lives and roil the digestion of subordinates; and nurses, residents, medical students, even secretaries tread cautiously when a prima donna is in full force" (p. 11). Şamil (25), a man newly graduated from a state university in Istanbul and planning to pursue a medical career in general surgery, interprets these surgeons' expectations from interns and residents as follows:

> They create a highly competitive environment. They want to see which intern or resident is the most ambitious one and open to challenges in surgical training. They want us to race with each other to show them our skills through which they decide who can be the *survivor* in their departments.

The notion of survivor is important here. Ardan (25) also describes the expectation of his seniors in terms of challenge and survival. As interns and residents have to survive in harsh conditions in surgical training, which is socially accepted way of training in surgical specialties, demanding and challenging educational methods become a so-called "constructive" way to lead juniors to strengthen themselves physically and mentally. When a patriarch yells at a junior, the expectation is that the junior has to pull themselves together and behave according to the demands of medical school and professors to be a good surgeon in the future.

We can suggest that when the proper way of improving surgical and professional skills for interns and residents is articulated in terms of challenge and survival, the understanding of

these male surgeons about being good surgeons in the future becomes handling the challenges. I have previously mentioned two male interns' account of professors being more offensive to male interns than women. Juxtaposing the articulation of the proper way of training through challenge and survival and the interns' claim that these senior male professors were harsher to men than women ironically shows the gendered expectations of these senior male professors. They construct the proper way of training juniors as cruel treatment of them to see who will survive. Even though most of the men interns do not like this situation as much as women, it provides more opportunities for them to learn from seniors and build a good rapport with them in the end. The notion that male interns build a good rapport with them is revealed in Elifnaz's observation: "After so much yelling and challenging demands, these interns and the professor take a cup of coffee together."

I suggest that this disciplinary and oppressive attitude can be turned into an advantageous position for men interns and residents. Conversely, in a context where getting angry or yelling at interns and residents is the only available training tool to attend their educational process and improvement, being deprived of it causes a feeling of exclusion and invisibility. On the one hand, interns and residents complain about the unequal nature of the seniority structure and disciplining practices resulting from this structure. On the other hand, throughout their training, interns realize that accepting these practices and adapting the working environment are the only means available to them to prove their social and professional qualities to these professors. This is because the refusal to adapt to the negative aspects of social and institutional ways of conduct, including "punishments," means rejecting this sociability.

Here I would like to turn again to the previous account of Sema. In Chapter 2, Sema asserted that disciplining practices differ depending on the gender of a medical student since these practices are based on gendered prejudices. She said:

> As a matter of fact, both women and men can hardly endure the harsh conditions within the strict hierarchy of surgical training. But seniors do not aim to kick out male juniors. They solely want them to be tougher because being a surgeon requires being tough. On the other hand, when the resident is a woman, they prejudicially act worse to her. They think that women are so much more sensitive than men. Therefore, they must force her to be tough more than ever so she can overcome her sensitivity or leave the department. Women are expected to leave sooner than men. Then they are harsher than ever. The sooner, the better, they think.

At first, it seemed contradictory to me as subjects take differing stances towards the attitudes of senior male professors. On the one hand, in the account mentioned above, Sema argues that seniors aim to kick out women residents while they want men to be tougher according to the requirements of surgical specialties. She seems to claim that professors were harsher toward women residents. Thus, how can we understand the different claims? The first claim is men interns' account that seniors act more demanding and challenging to them than women interns. The second one is that seniors act worse to women to kick them out of the residency. The difference lies in the positions interns and residents occupy in the professional hierarchy. During the internship period in different specialties, interns are also in a thought process to decide which medical specialty they will choose for specialization depending on their experiences in internships. Moreover, the internship period is when senior male professors give career advice to novices according to their displayed social, professional, and technical qualities. As interns are about to be team members but still not yet, senior male professors approach them differently than residents. In this context, residents are the ones who passed TUS and already chose which specialty and institution they wanted to be in. They come to the university hospital as official colleagues of seniors, even though they occupy a lower status than first-comer residents, attending surgeons, and senior professors. If a bad incident does

not happen to decide to quit the residency, residents are future colleagues in the surgical community. However, interns are still medical students who are partly like “kids” or “the youngest children” of professors emerging from the concept of a master-apprentice relationship. Therefore, how to approach a woman intern and a woman resident also differs. Interpreting what they hear as rumors and gossip from their seniors, including women residents, women interns that I have talked with argue that senior male professors act worse to women residents to force them to quit the official residency even though senior male professors claim that they act harshly to all juniors regardless of gender. These professors think you decide to come here and handle the situation, whether you are a woman or a man. As a resident, she has to endure the process. The answer to why senior male professors act more harshly to men than women when the case is internship is that professors believe that male interns are an excellent fit to endure the process even during their internship. They are the ones who must see the complicated reality of being a surgeon early on. We can suggest that the perception of male senior professors towards woman change depending on the position they occupy in the seniority hierarchy. Nevertheless, both positions have gendered consequences for women in surgical training.

So far, I have analyzed my initial interaction with subjects when I went to a public health class at a private university in Istanbul and how interns described bad-tempered senior professors in surgery and their expectations from the interns. After discussing interns’ experiences with bad-tempered senior male professors, I asked my interviewees whether there were more easy-going surgical professors with whom they interacted. Like Elifnaz, three other interviewees, Burak (25), Şamil (25), and Nurhan (26), matched the image of a good-tempered senior professor with femininity. On the one hand, the majority of my interviewees said that any senior professor in a surgical department can go crazy during a difficult and risky operation, whether the professor is a man or woman. On the other hand, they argue that

a good-tempered surgeon in their everyday working environment, where there is no acute trouble, is seen to be more feminine than bad-tempered senior professors. I asked what they meant by "feminine."

Here is Rana (24)'s description of a good-tempered senior professor:

> Unlike an arrogant and aggressive type of surgeon and professor, I think the good ones are kind and nurturing. In our social environment, for example, break rooms, offices, or the cafeteria, they are gentle to medical students, their colleagues, patients, and other healthcare workers. They listen to you and care for you because you are *their* junior.

I told her that some of the interns said these types of professors are giving feminine vibes. Rana, in turn, interpreted this identification as follows:

> Even though this is not openly expressed, people view these professors that way, as if a man having feminine vibes is a degrading thing to avoid. When people do not see you acting the way socially accepted, they find excuses to say something bad behind you. Of course, I do not mean that people misbehave with these professors. Most of us like them a lot because they are the ones we can communicate with. Maybe we can say that they are the ones who do not display a toxic masculine attitude toward people around them. That is what makes them perceived as more feminine in people's eyes.

Through the stories of my interviewees, it is revealed that the subjects draw a picture of these seniors through concepts of masculinity and femininity, depending on the ways senior professors, most of whom are men, approach my interviewees. As the socially accepted view is that surgeons/professors show characteristics associated with masculinity, the ones "deviating" from this understanding are tacitly labeled as being more feminine. While these

good-tempered surgeons/professors are still expected to easily get angry when things go wrong in surgical procedures, they are also accepted to be more friendly than the so-called patriarchs.

I will now focus on the experiences and accounts of interns regarding the expectations of their seniors. The experiences of both interns and residents would have helped me understand the different treatment of women at each level of the seniority hierarchy for further research. However, this research focuses on the interview data with interns. This is first because the internship period provides medical students their first encounters with the hospital environment and surgical procedures. Secondly, their career path in terms of deciding on a medical specialty is shaped by their everyday experiences during internships.

According to the majority of women interviewees, the general image at various medical departments in their universities is that women are sensitive and fragile. Not being conscious of the sexism this kind of understanding entails, senior male professors define and recall women as "flowers." Being an extension of how women are described in society, defining a woman as a flower is to highlight traditional characteristics that a woman is obliged to carry. Nurhan, Elifnaz, Duygu, and Sema said women were expected to be physically thin, small, cute, and gentle to others in their everyday life in medical school. In addition to being physically thin, women are obliged to act through gentle, elegant, and small movements, not taking too much space, said Berk. They are compelled to smell nice, like a flower. They are accepted to be vulnerable to outside forces, such as an unexpected touch, like the way the wind might break the petals of a flower. Not suprisingly, there is a commonly used phrase in Turkey, that is "*Kadınlar çiçektir*,"[11] which shows us how this understanding of women as flowers in their universities are determined by broader social norms.

[11] It is translated as "Women are flowers."

This notion of a woman being a flower is reproduced in the everyday lives of woman interns in medical school. Sema's professor in general surgery told their team that he needed them to divide into four groups, giving each group "a flower." Sema's interpretation of the situation is fruitful in understanding how women perceive their experiences in medical school:

> He thinks that he is saying something nice. I felt too awkward when I defined by him as a flower. Rather than contemplating in which group I can be more effective, he is just considering my womanhood and sending me to that team merely because they do not have any women there for a specific procedure. They generally think that if they behave like that, women will appreciate them as they do not seem to discriminate against women. They want to be seen as a person who is aware of women's presence in the surgical team. He thought that this was a gentle move and a compliment. However, I am not in a surgical department to be flattered only by my womanhood. I want them to see my professional skills.

Like Sema, İlknur (26) experienced a similar incident in general surgery:

> I do not think that we are seen as equal to men. This discrimination has so many faces that sometimes you cannot even recognize it immediately. When you start an internship, they say, "Oh! What a sweet girl who came to our department!" What does he mean by sweetness? Am I not a co-worker? Am I not a future colleague? Okay, I understand they feel close to other men and behave them however they want, sometimes severely. (She stayed silent for a second.) But after their rude approach to him, they come close and have a good relationship in social life. What about me? They think that they behave gently to me by saying kind words. They act like I am clumsy and unskillful, as if looking sweet and lovely is the only thing I can achieve. They speak as if I come here to play and am a kindergarten kid.

These accounts show that seniors think that their discourse towards women is about being gentle to women and conscious of their fragility. They also believe that their attitudes are positive and for the benefit of women. However, women are not pleased to be defined as flowers, someone who can easily be broken, and fragile human beings who can not handle the challenges in surgical departments. In contrast, they feel not seen as equal partners in the working environment. Not being pleased by this situation is related to the fact that women are aware of the unexpressed tacit connotations of these "kind" words regarding their assumed limited skills. Neşe (25) is a woman who had newly graduated from a state university in Istanbul and wants to specialize in anesthesia. Her male professor told her that she was a sweet and quiet girl. Then, he gave a gendered career advice:

> He told me, "You are a sweet petite girl. You are quiet and calm. It would be best if you specialized in pediatrics. It fits well with you. Children will like you as you will also seem sweet to them." He does not think about my professional skills even for a second while giving this advice. He does not know my personality, whether I can get along with kids or not. I really do not like kids and do not know how to interact with them.

This advice seems to come from asserting that bodily appearance as being "sweet" and "petite" brings personal qualities, the ones socially associated with womanhood, by default. Even though the content has variations across societies, this sex-typing of certain occupations and specialties is reproduced to support the existing sexual division of labor. This assertation and many others that women have certain inner qualities for specific jobs are based on social norms that place people according to their assumed gender roles. In this context, women are associated with care and service work. The idea that women have so-called natural qualities to be moms echoes in this advice.

Sex-typing of specific tasks or jobs finds its place in allocating everyday surgical tasks within surgical departments. Several women interns said that they were not wanted in the operating room when an intern was needed. Professors ask whether there is a man intern since they think that women interns cannot endure the long hours of operation. Without knowing the technical skills of a specific person, they assume that women interns cannot hold the surgical retractor for long hours standing still. If a man intern is available, they call him directly to help with the operation. Neşe's account is significant here:

> They think physical power and strength are the most important things in an operation. They do not reflect for a second that physical strength is not everything in surgery. This understanding is so primitive. Moreover, if I need more physical strength that surgery requires -as they prejudicially assume that I do not have any- I can go to a gym to gain that strength. As much as I study for my classes, I can put this effort into my career too. But they exclude us from the beginning.

Several women interviewees who gave up choosing surgical specialties interpreted their decision in relation to others' perception of women's physical "inability." According to social norms embraced by certain professors in surgical departments, women are not capable of doing hard and complex surgical procedures as they are fragile and physically weak. They are seen to be "flowers," therefore, easily broken. Following this idea, on the one hand, women students' career choices in non-surgical departments are approved as "good choice" by these professors because, that way, women seem to fulfill social and cultural expectations, accepting and adapting what is proper for them. On the other hand, even in cases where women do opt for non-surgical departments from the moment they start medical school, their decisions are still read as "settling down" or "coming to reason." The irony lies in Büşra (25)'s observation below:

> When a woman ambitiously wants to pursue a medical career in surgery, friends and colleagues do not believe in her. They think she will probably quit the specialty or she can not handle the hardships she would face. Thus, most of the time, she lacks social or friendly support and encouragement. When a woman decides not to choose surgery because of social pressure and prejudices or because she does not want to spend her life in an operating room, they immediately say, "We knew it would be like this" or "She was already not a good fit for that." I get outraged when they claim that they know women are unsuitable for surgical specialties.

This observation shows that women are under pressure in many aspects. Firstly, they are advised by their seniors to choose medical specialties socially and culturally "appropriate" to a woman. When we discussed the underlying reasons of why certain professors advice specific spealties they think proper to women, all of the women interviewees said that professors think that women would have families and kids to take care in the future. According to this thinking, choosing surgical specialties might jeopardize the balance between professional life and familial responsibilities. As their womanhood and future motherhood are supposed to come first in constructing a personal identity, professors warn women, Duygu (24) said. While this warning is assumed to be well-meant and for the sake of women, women subjects' observations and interpretations of the situation reveal that women feel under social pressure. Now I will focus on how the perception of women's ascribed qualities and characteristics shapes and determines everyday practices and interactions in a working environment where becoming a survivor and challenger is highly valued.

I shaped and determined my questions according to my initial observation and interactions with interns at a private university in Istanbul. When I repeatedly heard from men interns that they were treated more harshly than women, I asked them how they felt about this situation and how they perceived and interpreted it. I also asked them what kinds of consequences the

different treatment of women and men might have and how they grasped this practice for women. The majority of men interns are not pleased to be treated harshly by senior professors. They argue that senior professors, especially the bad-tempered ones, make the working environment unbearable for juniors.

Moreover, men interns feel abused. Senior professors in surgical specialties act like commanders, and juniors are soldiers. Three of my interviewees defined this treatment as mobbing. But then, they told me there was no option other than overcoming the obstacles and challenges. I then asked what reasons senior professors had in mind regarding treating women more softly. Şamil said that women were more sensitive than men, and he saw his women friends crying when a professor yelled at her. He further said:

> Professors are reluctant to treat women harshly, not to cause a dramatic scene. As women tend to show emotional reactions to harsh treatments and tend to take everything personally, professors do not want to force them into something. They might think that rather than asking a girl to do something, there are several boys to do whatever professors ask.

Interestingly, Nurhan (26) agrees with Şamil's opinion that women tend to create social drama in the working environment. She told me that women were more prone to nurture resentment against someone behaving negatively toward them. Even though she acknowledged that the lack of resentment in men was because they eventually built friendships with these seniors and turned oppressive practices to their advantage[12], she nevertheless argued that men interns were more easy-going to work with. She claimed that "at least men do not create drama and

[12] This account is mentioned in Chapter 2, p. 45.

act emotionally." According to her, that was why senior professors also demanded everything from men.

Regarding how this challenging environment affects women, Ardan argued that women did not want to overcome the challenges. He said:

> It seems to me that women do not want to be surgeons. Not wanting to be a surgeon is their choice. I know that surgical specialties are hard to get used to the work pace. And the seriousness of the job we do is another issue. However, I do not see women challenging themselves. I do not see any exemplary woman who fights for what she wants. I know that the value system in surgical specialties is based on rewarding masculine traits, and surgical specialties are historically male-dominated. Nevertheless, if women show strength, focus, and commitment, they can overcome their own challenges.

Several other men interviewees, too, told me that women interns did not challenge themselves. According to them, women interns do not show their potential nor try to show *the survivor* inside. In addition to that, Berk (24) asserts that some women use the idea that women are sensitive and fragile to their advantage:

> More frequently than other types of women, especially fancy-dressed women in medical school, are understood to be sensitive and fragile. They are beautiful-looking girls who come to classes and internships as models. Seniors recognize this type of person. They do not harsh on these girls and do not force them into complex tasks. Those who are aware of this situation use it to their own advantage. For instance, I witnessed these girls come to exam days fancier than ever. I think that is to pass the training terms easily.

Berk's comments on women who dress nicely or prefer feminine clothing reflects his perception of women medical students and are subjective. However, as Berk mentioned this account as if it is accepted by everyone in medical school, this also might be about unspoken convention in their universities that women who dress nicely are not there to success, but to be fancy, which is highly discriminative and judgmental.

I asked women interviewees what they thought about these claims. Ayça (25) acknowledged that she was aware of the fact that senior professors were gentler to women interns than men. She said:

> I gave up specializing in surgery. At the beginning of medical school, I also wanted to choose surgery like my many friends. However, after giving up this career goal because of the harassing and abusive working environment of surgery, I decided not to go over my limits. I just had to pass compulsory internship programs. I did not want them to come down on me. I became okay with the idea that surgical professors did not believe in me or other women. That was why they did not force us. And that was okay, rather than letting them abuse my personal and professional limits.

When we discussed that professors were harsher to male interns than women with women interviewees, the picture for women differed. They agree with the fact that men interns try to meet the challenging demands of professors. Moreover, they agree that men interns mostly do the errands. Even though women interns are anxious about the potential mobbings and hardships when their time for residency comes, they think that internship is relatively easier for them than their male friends. However, all women interviewees base this social reality upon the fact that senior professors do not care about them. Sema, Büşra, Ayça, Neşe, and all the others told me they felt invisible.

Özge (25) argues that senior male professors, whether good-tempered or bad-tempered, do not expect too much from women interns. As I have previously said, she agreed with me that the meaning of residency was different for these professors. She said:

> Things get tricky when a woman chooses a surgical department after TUS. We hear rumors about how and why seniors did not want women in their departments. I did not witness this kind of thing with my eyes. Nevertheless, I heard that when the news came that a new woman residency was on her way, everyone got curious about how she would adapt to their social environment. Things are different for internships, though. The internship is itself a temporary job. You are not their co-worker yet. When you are both a woman and an intern, you are totally invisible.

I asked whether this was related to the social norm that women were sensitive and fragile. She agreed with me and added:

> Professors think that women eventually will not choose surgery. We are seen as temporary workers there. So they say, “Why the hell are we going to bother with their whining?” And they leave women alone. For some women, having a chill environment is totally okay and indeed good. Yet, for some other women who crave to be a professor's favorite, that is hard to accept. They have to put extra effort into proving themselves.

In this context, senior professors advise women to choose medical specialties appropriate to the so-called social and cultural roles of women. As they think that women will primarily consider their comfort for their future career goals, they perceive the presence of women interns as temporary. Therefore, they try to guide them to specialize in pediatrics, dermatology, physical medicine and rehabilitation, and so on. However, when a man wants to specialize in these specialties, professors think he would be wasted. According to these

professors, men can not show their true strength and power, which they displayed during their internship in surgical specialties. The wise choice for men becomes choosing surgical departments, considering the fact that these professors need someone like them to hand over the profession. Thus the master guides the *true* apprentice, the natural heir of him, while he ignores "the flowers."

3.3. "Innocuous" Sexist Jokes and Homosociality

When I first asked my interviewees whether there were sexist attitudes or practices, the majority of my interviewees compared the current social and institutional context with the past. Through that comparison, several subjects recounted the histories of overt gender-based exclusions and direct sexually harassing behaviors. They mostly agree with the idea that now there are social and institutional policies towards gender equality and women's empowerment, which results in *less* hostile working environments for them. The comparison allowed them to understand today's conditions in a relatively positive and progressive manner. Some of the women subjects told me that they did not come across any direct negative attitude regarding their gender in medical education. However, after the initial questions, when we dwelt into interpreting the seemingly more inclusive and non-discriminatory interactions, we came to the understanding that some of the acts of their colleagues bothered them in different ways, but they did not relate them to gender-based inequalities and discrimination at first sight.

In the previous subheading, I analyzed the expectations of senior professors in surgery from women and men interns in the *survival* context of surgical training. While women interns feel invisible and temporary in surgical specialties, men interns complain about the harsh treatment of themselves by senior professors. This situation creates an exclusionary attitude towards women where they understand the attitudes of professors as not expecting too much from them. Women's assumed indifference to surgical procedures and training and the so-

called inability to challenge themselves have a different meaning for women. They understand themselves having started the internship with the extra burden of "being woman" in order to prove their competence and technical skills. They observe that they are not wanted in surgical specialties. In addition to that, when we look at the issue from men interns' side, the practice of calling seniors *abi/abla* creates a social environment where men interns turn this practice to their advantage by building a friendship with these seniors, who are mostly men. However, men interns are still at the bottom of the seniority hierarchy and vulnerable to abuse and mobbing by their seniors.

Nevertheless, even if the nature of friendship is unequal and hierarchical, men interns still find ways to adapt to the working environment and try to climb the professional ladder. Interestingly, these patterns, attitudes, and practices unfold in a social climate where feminist and gender equality discourses increasingly surround medical school. Consequently, gendered practices are reproduced under a disguise where the so-called ameliorative steps are taken. Yet, in women's social reality, gendered practices still bring invisibility, exclusion, and unadaptability. The analyses at hand, I will now focus on the seemingly friendly relations and conversations between men at each level of seniority structure and how they reproduce the gender structure of surgical training, as I have said, *behind the doors* now.

The majority of women interviewees experienced gender-based discrimination through sexist jokes in the working environment of surgical specialties. Some of them interpreted sexist jokes as innocuous and "just for fun between men." In contrast, the others argued that they did not belong to a social environment where men constantly joke about women, their bodies, and their sexuality. Even though sexist jokes are mostly not toward a specific person, Ayça told me that she had nothing to add to this kind of conversation and felt degraded by the image of womanhood these jokes represented. Ayça further said:

> Men make sexist jokes for fun and to build close relations with each other through these jokes. Sexist jokes for them are like an ice-breaker. For women, sexist jokes and the surrounding they are voiced are exclusionary. Firstly, when a man senior wants to make a sexist joke, they "politely" ask women to leave the break room. Secondly, if men at each hierarchical level make a sexist joke *around* women, they immediately drop the accusation of sexism by labeling their acts "innocuous."

Women and men interns define sexist jokes as *bel altı* (below-the-belt jokes), which are sexual about women and their bodies or sexual activities. Below-the-belt jokes can range from a so-called compliment to a woman's body and sexuality to "jokes" about men's sexual power, rape, unwanted sex, men-centered sex positions, and penetration. Ardan's one close female intern friend experienced this kind of joke directly targeted at her:

> Do you know the ID cards we carry in the hospital? Our names, ID numbers, and positions are all written on it, whether you are an intern doctor or an attending surgeon. This friend of mine did not like this card to hang her neck. During the incident, she was not swinging the card on her neck as it should be. Professors want us to carry these cards that way. When he asked her why she was not carrying it, she told him that she disliked swinging things. And in return, he laughed and told her, "Then it is a good thing you are not a man. It would be bad for you, you know?" Which part of this joke should we laugh about? Does he think that we can not understand what he means? He is talking about dicks that are swinging. This is disgusting.

Ardan interprets this occasion as the professor holding power over her. He is the senior and knows that she could not backlash his unwanted sexual joke. As another example, Özge told me a story that she interpreted as an "extreme" and "horrible" case:

> I heard that men residents shared amputated women's porn after an amputated woman patient's photos were shared on the Whatsapp group of a urology department at a state university in Istanbul. The aim of sending patient's pictures after the operation was to evaluate the operation and follow up on the post-surgical needs of the patient. But then, why amputated women's porn? How can you explain this horrible thing that happened? How can they make fun of a young woman who lost one of her body parts? Is it ethical for a medical doctor who swore an oath? What about patients' rights? How can they joke about the suffering of a patient on a semi-private space? I know that it was their Whatsapp group. But, in the end, you can see that we all know the incident. As people from other universities, all of us know.

Then, she argued:

> The urology department is the most male-dominated one. We all hear that male patients do not want to be treated by women urologists. However, people do not understand that urology is not just about a penis. Even if it was, then why are there thousands of men gynecologists but a few women urologists? As a society, we can not think of a penis other than being a sexual organ. Then, in this kind of society, we say that women are not able to overcome obstacles. We say that women are fragile and do not tend to face challenges in surgical specialties. Even if you become a urologist, it is hard for a woman to practice. Before that, how can I find a place myself and feel committed to my job where men share porn however they want? It is their ground where they show how masculine they are.

Özge's questioning of not finding a place for themselves is important here. When I asked men interns why women did not choose surgical departments if they were all welcome, the subjects interpreted the issue as women's "free choice." However, Özge's emphasis shows

that the concept of choice is not free but full of social and structural obstacles that women face. From the beginning, women feel uncomfortable and think they will not belong to a place where womanhood is a matter of sexist jokes. Moreover, practices to perform masculinity in the working environment is not something the subjects are pleased to see. Calling women's preferences of non-surgical departments or the fact that they give up a surgical career later on a "choice" is to disguise the existing unequal power relations and sexist and gendered practices enforced by these power relations.

Six of the women interviewees told me about a similar experience they shared and lived through. They told me that, in everyday life at surgical departments, seniors repeatedly use a common phrase: "*Şimdi bir şaka yapardım da kadınlar var yapamıyorum,*" or with different wordings, "*Şimdi bir şey derdim de kadınlar var.*" The two statements can be translated as "Now I would make a joke, but there are women, I can't." In one occasion, Nurhan was sent outside the break room after this statement had been used. A professor "politely" asked her to leave the break room to make his sexist joke. Furthermore, Nurhan told me that several other women friends had also lived through this experience. Here I would like to mention Daghan's account for an explanation of why men do this and continue to make sexist jokes: "I make sexual jokes too. Sometimes professors do with us too. I find sexual and other offensive jokes hilarious. I guess I can say that I do a lot. But it is just for fun on a tedious working day." I asked him whether he understood making sexual jokes like doing whatever you want in a safe place/zone. He said:

> Yes, I think exactly like that. In your safe zone, you sometimes do things that society might not accept easily. Continuing the conversation and laughter becomes funnier when it is amusing. And I also think these jokes, for example, make us friends with an *abi* (brothers) more quickly than any other topic.

Then I asked why they sent women out during these conversations. He explained to me that women were more sensitive than men regarding offensive jokes. He refused my argument when I told him that this was because their jokes were sexist and misogynistic. He argued "Yes, they are sexist in content, but I do not think that we are misogynists. It is just a joke. You can make a joke out of everything in life."

While Daghan claims that they "do things that society might not accept easily" in their "safe zone," it is essential to highlight that, in contrast to his claim, making sexist jokes in public and between male friends is something to show how much you are adapted to the team and the social milieu of surgical training. Against his claim, I argue that making sexist jokes is an easy ticket to building good friendships with your seniors and belonging to the social environment. Moreover, male senior professors, who have total power and control over their subordinates, participate in this "play between boys." Therefore, again, rather than describing sexist jokes as something like a guilty pleasure done with close friends not to be judged, they are openly made and enforced by these men. And the zone becomes safe for boys but not for girls. Though girls are even sent out from the break room to make the zone "safer."

Another aspect I will focus on is why some of the male interviewees in my research do not accept the wrongful element of what they do. Why do they define their acts as innocuous when a woman openly says things said were hurtful and degrading? Catharine MacKinnon, a radical feminist scholar, in her book *Sexual Harassment of Working Women*, argues that sexual harassment of women happens largely because women occupy inferior job positions and roles; at the same time, sexual harassment itself works to keep women in such positions (1979, pp. 9-10). Consciously or unconsciously, male subjects keep women in their place by expressing sexist and gendered statements and creating a homosocial working environment. To do that, they must trivialize their acts not to get objections and to protect and maintain the existing power relations. According to MacKinnon, jokes represent another form through

which society exerts control over women. Objecting to them is taken by men as the degradation of male humor. Moreover, they trivialize sexual harassment cases, composed of light forms like verbal sexual suggestions and jokes or severe issues like forced sexual relations, as a major means of enforcing its invisibility (pp. 51-52).

I argue that, in their everyday working environment, women interns face sexist arguments about their capabilities, professional and technical skills, and sexual jokes about their bodies and sexuality. Those who interpret sexist jokes as innocuous seem to accept them as a play between boys. They also understand the issue as "boys will be boys,"[13] a classic acceptance of a masculine image in Turkey's context. What is interesting is that even those women interns who interpret the sexist jokes as innocuous conclude that they do not feel belonging to surgical specialties in the end as surgical specialties are like boys' clubs. These women's attitude toward boys' "classic" behaviors seems to be because these women think that any reaction to these acts would be futile. Therefore, agreeing with what MacKinnon suggested, sexual harassment, whether just a joke or a play between boys, works to keep women where they are and simultaneously keeps them away from where men dominate.

I argue that the working environment in which men at each level of seniority hierarchy make sexist jokes and comments about women and where women are sent outside to make these jokes becomes a homosocial space, making things easier for men to adapt to the socialization processes. For men interns who do not make sexist jokes and do not like the environment enforcing these jokes and sexist arguments, the surgical training space and learning processes are relatively harder to endure. Berk told me he was unhappy and unsatisfied with being part of such an unequal and exclusionary power dynamic in the surgical specialties. He said:

[13] "Boys will be boys" is a commonly used phrase in English-speaking world. In Turkish, it is commonly said "Erkek işte" which has a similar meaning with "Boys will be boys."

> The only available means for finding a place for yourself in surgical specialties is to comply with the social practices and behaviors even if you do not like them. I know that I must keep pace with the demands and expectations. Yet, I also know that I contribute to reproducing the existing unequal social relations by following the traditional surgical training requirements. If you want to make friends here, you should be like them. However, at least, I try to be conscious as far as I can and find other people to socialize with rather than these rude men, from interns to senior professors. Maybe I do not regularly object to sexist jokes and practices excluding women. That is not a politically active position, I know. Nevertheless, I try not to be like these men. Now I see myself and my role in surgical departments during my internship as temporary. I have to endure these horrible practices with my friends, who also complain about the general characteristics of surgical departments the way I do. Then I will go to another specialty as a resident and not be part of this anymore.

Berk's accounts reveal that not performing the required masculinity, or with the well-known concept of *hegemonic masculinity*, accepted by the surgical working environment and its social actors, makes the social life in surgical training hard and incompatible with nonhegemonic masculinities.

In the article *Sexual Harassment and Masculinity: The Power and Meaning of "Girl Watching"* (2002), Beth A. Quinn analyzes the practice of girl watching, which she describes as "sitting on the blurry edge between fun and harm, joking and harassment" (p. 387). She finds girl watching "both a source of fun and a mechanism by which gendered identities, group boundaries, and power relations are (re)produced" (p. 393). In line with her arguments, my research also shows that, through these sexist jokes in everyday working environments and social relations, men at each level of seniority structure construct their group boundaries and decide who is going to be included. That way, the existing power relations and

inequalities are reproduced as we see that women do not feel they belong to the social environment of surgical training and often give up choosing a surgical specialty for their future professional life. Several interviewees told me they gave up specializing in a surgical specialty because of the strict seniority structure and associated gendered discourses and practices. Therefore, the social acceptance that men are natural occupants of surgery, which is profoundly gendered, is reproduced. Secondly, the seniority structure and hierarchy are maintained when men interns adapt to the homosocial relations in surgery. They contribute to and enforce the existing system. Men who comply with the demands and expectations of their male seniors and the seniority structure will probably become the next generation of seniors without questioning what they have been through during their internship and residency.

The concept of homosociality describes and identifies social bonds between persons of the same sex. It is commonly used by gender and masculinity studies to understand how men bond, build social relations within closed boundaries, and defend their privileges and positions in a group or society. Through the concept of homosociality, we can see how men control, maintain, and reproduce patriarchal relations that privilege and protect their social norms and roles. This research too reveals that men in surgical specialties construct closed boundaries and reproduce their privileged positions in surgical departments. While doing that, they also advise women what to do and what not to do through their powerful positions in the seniority structure. The less powerful ones, such as those at lower ranks of the seniority hierarchy, also contribute to the existing system, even though they suffer from the injustices of the seniority structure as much as women. Therefore, we see that, despite the relatively less hostile working environment for women in contrast to the past, women still face exclusionary and discriminatory practices, which affect their specialty choices. The seemingly more friendly practices are revealed to be still highly gendered but in new disguised forms. In addition to keeping women in their place -also meaning keeping them away from surgery and

directing them to non-surgical specialties through gendered career advice- men also perform their masculinities and try to find a place for themselves in the accepted forms of masculinities, *the hegemonic ones*. The issue becomes how much "boys will be boys." Then, they show how masculine they are at the public stage of surgical training.

3.4. Conclusion

In this chapter, I have discussed everyday gendered relations, interactions, practices, and discourses, which shape the experiences and subjectivities of medical students and affect their specialty choices. While the majority of my interviewees compared the current environment with the past and concluded that the working environment was relatively more positive and progressive towards women, we saw that gendered practices and discourses persisted and reproduced in new forms.

To understand the disguised forms of sexism and gendered practices embedded in the seniority structure and hierarchical relations, we looked at what seemingly friendly and gentle movements and statements meant for women. It is revealed that women are identified as sensitive and fragile, like "flowers." They are defined by senior male professors and other colleagues in the working environment where the concepts of survival and challenge are enforced as "not challengers." Therefore, they were accepted as not suitable for surgical tasks and jobs. However, for women, this perception made them feel that they were not wanted in surgical specialties. They did not feel they belonged to the working environment of surgery and saw their position during internships as invisible and temporary. This understanding enforced by gendered hierarchies of power is related to the established social expectations in medical school, which assign gendered characteristics to medical specialties. According to these established social expectations, men are the natural occupants of surgical departments, and women are not.

The everyday experiences of women show that the attention to their so-called "womanhood" comes first than their technical and professional skills in medical school. From the beginning, they come to surgical departments where social actors see them as incapable of the job men do. Moreover, the working environment is a male-dominated space. I call this a *homosocial club* to highlight how women are excluded from the everyday social life at surgical departments, in addition to being defined as sensitive and fragile, in other words, as "flowers."

In this homosocial club, men do make sexist jokes and comments about women, their bodies and sexuality, and sexual activities from a patriarchal and gendered perspective. This practice, not always targeted at a specific woman, is to build close relations with men interns and their seniors and reproduce the existing gendered privileges and positions. Moreover, this practice helps men interns, residents, and professors create a relaxing environment by using sexist slang and jokes as an ice-breaker. The most important thing is that, through sexist jokes and comments, men show their masculinity, complying with hegemonic forms of masculinity, to get involved in the team mainly composed of men. Making sexist jokes is an act to show others that he is one of them and he will always be. He shows them that he is a boy and *boys always will be boys*. However, for women, even those who interpret sexist jokes as fun and solely a play between men, they still do not feel they belong to surgical specialties in the end, as surgical specialties are like boys' clubs. In this context, while women are sometimes tacitly sometimes openly directed to non-surgical specialties rather than surgical ones since they are not seen as equal partners in surgical training, male bonding prevails and (re)produces the existing unequal relations and gender-based discriminations against women.

CHAPTER 4: SUBVERSIVE PRACTICES OF WOMEN AND LGBTI+ MEDICAL STUDENTS

"The collective is an open space of ambivalence and contestation where there is room for tentative bonds and shared frustrations to cross entrenched boundaries and mark out new ones."

(Biehl and Locke, 2010, p. 327)

4.1. Introduction

My research deals with unequal power relations in surgical training through which gendered hierarchies, practices, and discourses are constructed and maintained. These gendered hierarchies, practices, and discourses not only shape and determine everyday life in surgical departments but also affect women's career choices in medical specialties in ways to reproduce the existing unequal power relations in medical schools. I benefited from Foucault's understanding and theorization of power to understand these power relations. However, as he is criticized for taking any kind of resistance as a mere reaction to power, in this chapter, while I intend to grasp the subversive practices of women and LGBTI+ medical students, I will benefit from Biehl and Locke (2010)'s conceptualization of power and resistance.

Against Foucault's conceptualization of power, subjectivity, and resistance, Biehl and Locke (2010) argues that "people are not just the sum of forces -however overwhelming- constructing and constraining them" (p. 332). Instead of understanding subject as passive objects determined by structural forces at work, they argue that individuals maneuver around obstacles and persist in their efforts, "carving out small life chances against the odds" (p. 332). By drawing inspiration from Biehl and Locke's critical perspective, I want to examine

how my interviewees resist the conditions that construct and constrain them and carve out life chances against the odds in medical school. Approaching the subjects as passive recipients of structured institutions and denying their efforts to ameliorate the conditions they have - however small and seemingly futile they are- would be insufficient to capture the very efforts that might lead to a substantive change toward gender equality in medical school in general and surgical training in particular.

Previous chapters showed that in surgical training in Turkey, gendered rules and norms are enforced and maintained by the seniority hierarchy, normative assumptions about women's physical and mental capabilities, and gendered discourses. This gendered structure is embedded in the organization of the seniority structure and hierarchy, with its top actors as senior male professors. Nevertheless, many subjects criticized and challenged this seniority structure and entrenched patriarchal habits. Firstly, I will discuss the communal strategies of medical students and interns who built a communication network to inform each other about, for instance, senior professors who have aggressive and hostile attitude toward interns, especially women interns. Secondly, I will focus on two feminist and queer organizations established by women and queer medical students and professionals to eliminate gendered perspectives, discourses, and practices in medical school. Before moving on to the subversive practices of women and LGBTI+ medical students, I will examine what I mean by Foucault's conceptualization of power and resistance and why it is not enough to understand people's efforts against unequal power relations.

For Foucault, power is not something that only represses and dominates. He conceptualizes power as omnipresent (1978, p. 93), as a web, diffusing and circulating everywhere and emerging from different social relations. He describes the omnipresence of power as follows: "not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation

from one point to another. Power is everywhere." (p. 93). The understanding of power as omnipresent was helpful for me to grasp the organization of medical school and surgical training as a totalizing institution, a panoptic-like mechanism, where constant control and surveillance are enacted. This way, I focused on how this way of organizing, regulating, and disciplining medical students through rewards, privileges, and punishments affected interns' understanding of the self and their perceptions of others, i.e., their colleagues, from interns to senior professors.

According to Foucault, modern power operates in everyday life, shaping and defining individuals by their individuality, binding them to their own identities, and compelling them to adhere to a truth that they and others around them must acknowledge. (1982, p. 781). Then, he argues that this form of power transforms individuals into subjects, encompassing two interpretations of the term "subject." First, he says, it involves being subjected to someone else through control and dependency. Second, it involves being bound to one's own identity through a sense of conscience or self-knowledge. In both senses, this power exerts dominance and subjugates individuals, subjecting them to its influence (p. 781). Thus, we can suggest that this kind of power in medical school as a totalizing institutional setting shapes interns' subjectivities and decision-making processes.

In *History of Sexuality Volume 1: An Introduction* (1978), Foucault says that "where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power." (p. 95). A significant issue arises in this portrayal of power and resistance: resistance is depicted as entirely reactive, merely responding to power rather than being an independent and proactive force with its own agenda (Hartmann, 2003, p. 4). According to Hartmann, Foucault's later question in the 1980s, which emerged in the text *The Subject and Power* (1982), was how to have a "positive means of resistance which does not devolve to re-action or negation" (2003, p. 4). In this text, Foucault argues that "power exists

only when it is put into action" (p. 788) and, he says, it is always "a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions" (p. 789) by *free* subjects. Hartmann, in defense of Foucault and his conceptualization of power and resistance, argues that emphasizing how actions affect one another, i.e., understanding power relations as actions upon other actions, sheds light on the positive aspect of the subject's ability to act upon themselves or the relation of oneself to oneself. He further says if power operates by shaping the range of possible actions, resistance should go beyond mere oppositional force relations and involve creatively exploring the possibilities within the field of action. Resistance is no longer just about reversal; it consists of a subject achieving autonomy within structured institutions and practices through immanent critique (2003, p. 10). Even though this later understanding of resistance opens up more space for a non-reactionary conceptualization of resistance, I intend to grasp a subject position "that is as much about swerves and escapes as about determinations" (Biehl and Locke, 2010, p. 335).

4.2. Communication Network as a Solidarity Mechanism

While my interviewees shared their experiences with gendered hierarchies, discourses, and practices in the everyday social environment of surgical training, they also shared the strategies and techniques they create and use to ameliorate or change the existing conditions. Even though some strategies they use are not to make an overall change, I argue that they are still important as the subjects "carve out small life chances against the odds" and find ways to endure or lessen the burden of unequal relationships.

One of the main strategies used by my interviewees was to create social media platforms and instant messaging groups, such as Facebook groups, Whatsapp chat groups, and forum sites, to get information about the strictness of the seniority hierarchy in a given institution and medical specialty, and the degree to which medical students and interns face abusive attitudes,

sexual harassment, and mobbing in that specific institution. I asked whether they trust the administrative processes in terms of the protection of rights and complaint mechanisms in cases of violation of rights and rules if they would have complained about gender discrimination, sexual harassment, mobbing or any other discriminatory practice. The majority of women interviewees told me that they did not trust any legal procedure or a complaint file to be taken care of by their institutions' administration. While the women in private universities were relatively more optimistic about the institutional mechanisms, all of the women interviewees in state universities said they did not trust the administrative people in charge. İlknur (26) said, "Even if a complaint file can easily be opened against a person at the lower ranks of the seniority hierarchy, I do not think that people in powerful positions will face the consequences of what they do. As usual, they do not." She thinks that if she comes across a mobbing incident one day, it would be futile to tell authorities in medical school about what happened, especially if the perpetrator is a senior professor.

Like İlknur, Sema also does not trust the administrative and institutional processes in terms of following up the violations of rights and rules or a case of discrimination. She argues that the administration would probably decline a formal request and instead, they try to "solve" the problem "in a friendly manner" between the parties involved. She had lived through an internship in pediatrics where one of the assistants had a constant aggressive attitude toward her. Even though the department asked for feedback from interns about how their training went there and what interns would suggest to do things better, Sema did not report the attitude of this assistant, who was then a resident in pediatrics, meaning that he was her senior. The reason behind her silence was her untrustful perspective on the feedback and complaint mechanisms. When I asked why she stayed silent, she said:

> I do not think that they ask for feedback to change anything. It is just a formality. Other than that, I know what I say will immediately be a gossip thing. Everyone will

> learn, and the person I gave negative feedback about will also know. Then, they might make things harder for you when they hear that you complain.

Moreover, her untrustful perspective has a substantive base:

> The dean organized a meeting where we discussed how a problem related to harassment and mobbing should be dealt with progressively. We asked where to apply for a mobbing issue. The deputy chief physician said, "Sure, there are places where you can go for a formal complaint. However, we do not recommend this kind of attitude. Instead, the best solution is to develop good communication skills and diplomatically solve the problem. We should talk about the problem directly with the person involved. Because if you formally complain, this might be like snitching on a colleague, which complicates things. And your relationship might become worse with many people. We do not want that because, you know, we are colleagues." After this kind of discouraging speech, how can I trust the administration at this university?

The speech given by the deputy chief physician is more than merely discouraging. There is also a subtle threat that the complainer's relationship with many people might worsen. Sema's fear that they might make things harder for a complainer finds its substance in the deputy chief physician's words. Moreover, what he offers as a "diplomatic" solution is about silencing the harassed and making things easier for the perpetrator. What he means by diplomacy is about making the case smaller, as if the issue at hand is a friendly problem that can be solved by speaking about it behind doors. In a place where the seniority structure and related strict hierarchy are diffused in everyday relations, talking to a senior about what he did wrong is a stressful and sometimes impossible act to do. As we see in Sema's case, the complainer will either be silenced or choose to remain silent for fear of being silenced. Sema's account is highly illuminating as it shows how frequently various minority groups

face different forms of discrimination in institutions established and maintained by the powerful ones worldwide, and the institutions give the same answer everywhere to reproduce themselves.

In her influential book *Complaint!* (2021), Sara Ahmed, a well-known feminist scholar, gives the example of a university student who made a complaint about sexual harassment to the dean and the dean's answer to her, resembling Sema's case: ""The dean basically told me I should sit down and have a cup of tea with this guy to sort it out." So often a response to a complaint about harassment is to *minimize harassment*, as if what occurred was just a minor squabble between two parties, what can be sorted out by a cup of tea." (p. 272). Ahmed argues that a complaint can *ironically* be how we learn about institutional violence, the violence of institutions reproducing themselves, the violence of how they respond to violence, or solve the problem violence caused. In Sema's case, we can suggest that even before a complaint, the subjects might sense the possibility of institutional violence by interpreting the deeds and words of the senior people. We see that institutional resources can be mobilized to stop those trying to complain or those who bear in mind the possibility that someday they might need a complaint. As Ahmed highlights, those who try to complain or will probably need a complaint in the existing gendered and discriminatory environment "feel the institution as weight, as what comes down on them." (p. 267) Thus, the deputy chief physicians' words can be interpreted as *what comes down on* Sema and many other women in medical school.

İlknur and Sema's accounts helped me see that most subjects find the institutional setting overwhelmingly untrustful. Then, I asked what they do when something is wrong, or they face discrimination. It is revealed that medical students create their own ways of solidarity before coming to the administration. Ayça (25) told me that they had Whatsapp groups where they found out news before choosing a specialty or a department to do their internship:

> As interns, we start our internships in different specialties. Some of us begin with surgical specialties, and some prefer to be an intern firstly in internal medicine, etc. Since we all rotate between different specialties, we learn what happens in each. For instance, once, we heard that a male resident in the gynecology department was trying to flirt too much with female interns and making them uncomfortable. As I have already done with my surgical internships, I decided not to choose another one and erased that department from my options. I was not going to be a gynecologist anyway.

I asked her what would have happened if the gynecology internship was compulsory for graduation, as somebody like him might be anywhere at any time. She said:

> I know this is a limited form of solidarity for internship since you must complete your internship period mainly in the university where you are getting your degree. Therefore, you do not have that much choice but go there. Yet, at least we know that there is a playboy there. (She gave me a nervous laugh while saying "playboy.") You could draw your wall against him beforehand not to be crossed, or you just know what to expect there, and consequently, you will not have high hopes.

Many other interviewees, including men, using these social media platforms, i.e., Whatsapp groups, forum sites for students who prepare for TUS, student community accounts on Twitter, to learn about the social environment in various departments and the degree of strictness of the seniority structure in each, interpreted the communication network as a limited solidarity mechanism. Nevertheless, they also interpreted it as a powerful tool to deal with constraining and disciplining mechanisms in medical school. In the end, they use these platforms as a form of navigating between different forms of inequalities and abusive relations. Moreover, for residency periods, women graduates of medical school use these networks to choose the specialty and the institution after they get their TUS (Medical

Specialization Exam) scores. When they determine which medical specialty to choose, knowledge about different institutions helps them decide which one is safer to add their preferences list specifically. The fact that the majority of women must consider where they will be safer and more peaceful and which institutions are relatively freer of abusive conflicts, sexual harassment, and daily gender-based discrimination shows us the significance of communication networks as a solidarity mechanism and powerful tools to navigate through injustices and inequalities within the seniority structure in medical school. We can suggest that where there is no institutional mechanism to create a progressive and egalitarian working environment for all, and indeed, the institutions themselves reproduce the violence by not doing anything or minimizing the severeness of harassment and mobbings to protect the status quo, communal strategies for solidarity become spaces for coming together and lessening the hardships together in medical school.

4.3. Feminist and Queer Organizations for Medical Students and Professionals

Women medical professionals and students who problematize the sexist and gendered culture of medical school and surgical training get organized through many organizations in Turkey. They try to challenge social and cultural biases against women in medicine, both women as patients and women as medical professionals. While there are various feminist medical professional organizations around Turkey, I will focus on two of them as their members are primarily composed of medical students, which is directly related to my thesis. The first one is established by Turkish Medical Association (*Türk Tabipler Birliği, TTB*), whose name is Medical Students Organization Women's Studies Group (*Tıp Öğrencileri Kolu Kadın Çalışmaları Grubu, TTB-TÖK Kadın*). They work in close contact with the Women Physicans and Women's Health Studies Group under the umbrella of Turkish Medical Association. The second one is a newly established queer medical students collective, whose name is LGBTIQA+ Medical Students' Collective (*LGBTIQA+ Tıp Öğrencileri Ağı*). They organized

a workshop as their first event in July 2023, where they discussed the form and content of the organization and did strategy planning.[14]

Firstly, I would like to analyze the directives of *Women Physicians and Women's Health Studies Group* and *Medical Students Organization Women's Studies Group*, their activities, meeting reports, and their collaboration with other feminist groups. In the document of directives of *Women Physicians and Women's Health Studies Group*, the aim of the group and their fields of struggle are stated as follows: discussing the problems of female physicians arising from gender discrimination, analyzing the social and cultural aspects of being a female physician, providing equal, free, qualified, and accessible healthcare services to women, deconstructing hegemonic and patriarchal male-dominated discourses in biomedical knowledge and practice, focusing on scientific studies on women's health, being in close contact with other feminist groups and struggling against the patriarchy together in all aspects of social life, and creating an organizational climate that will increase the participation of women in medicine (TTB, 2022).

In the report of Being a Female Physician Workshop (2019), held by both medical professionals and students, women physicians state that women physicians' problems in professional life arise from traditional cultural patterns, the structure of medicine, and opportunities in education. These problems become apparent for women, especially in specialization preferences, professional and academic promotions, recruitment processes, and decision-making mechanisms (p. 1). They also argue that the male-dominated environment and social actors in medical school suppress and masculinize women's gender-specific appearance, question women's scientific and professional competence and make women

[14] Only medical students were allowed to the meeting. Therefore, I do not have first-hand detailed references to the meeting, the content, and the strategies they put forward. I tried to collect information about them through their official Twitter account.

question themselves in return, and undermine women's self-confidence, which lead women to put extra effort to be on an equal footing with their male counterparts. Moreover, in line with my arguments in previous chapters that homosociality between men in medical practice and training creates opportunities and privileges for men, they also highlight that women are excluded from social networks and social and physical spaces do not meet women's needs as they are arranged for the traditionally accepted occupants of the medical profession, in other words, for men.

I also would like to specifically mention one of the experiences and testimonies of women given in this report:

> In the medical field, the concept of "surgeon" is socially associated with "male," which leads women surgeons to feel the pressure to prove their competence and sufficiency to their colleagues from other specialties and healthcare staff when they start working in new institutions, despite being experts in surgery. For instance, situations like a surgery taking longer than expected or asking assistance from a fellow surgeon during an operation, which happens to all surgeons, are often attributed to the difficulty of the case for male surgeons. In contrast, female surgeons are more likely to be seen as inadequate. Working with this preconception, many female surgeons feel more stressed during surgical procedures, affecting their decision-making processes negatively. Surgical skills improve with experience, the number of surgeries performed, and long-term follow-ups of surgical outcomes. However, due to gender-biased perceptions of women's abilities, many female surgeons opt for fewer surgical procedures and prefer more passive roles (p. 6).

In this context, with the presumption that surgery is a male specialty and men are natural occupants of surgical positions shown in the quote above, feminist organizations aim to

deconstruct these gender-biased assumptions and raise awareness among women and men in medicine. They want to encourage women physicians and students to actively oppose these discriminations and speak out against patriarchal codes and conducts. Organizing an event in which experiences and testimonies of women are shared publicly is essential to help many women physicians to give meaning to their personal experiences. As patriarchal norms and expectations try to reduce women's self-confidence in professional life, sharing the aforementioned experience with other women provides an opportunity for those who understand the issue as a personal problem and blame themselves rather than seeing it as a result of patriarchal mechanisms. That way, many women can see that this is not personal but social and political.

Following the economic and political conjuncture of Turkey, in solidarity with other feminist organizations, these feminist medical organizations attempt to touch upon the increasing societal problems and protest against patriarchal and capitalist powers in Turkey. With the rising authoritarianism and anti-gender politics of the AKP government in Turkey, the feminist and LGBTI+ movement is under attack by the state and its actors. For instance, at the graduation ceremony of Çapa Medical School (*Çapa Tıp Fakültesi*), the dean censored the part related to the non-discrimination policy regarding sexual orientation during the Oath of Medicine (*Hekimlik Andı*) was read. Students, mainly from *TTB-TÖK Kadın* and *LGBTIQA+ Tıp Öğrencileri Ağı,* did not allow the censorship to pass. They read the oath completely.[15] In Turkey's current social and political context, produced and enforced by the nationalist-conservative familism narrative of the AKP rule, feminists are seen as sexually immoral, fighting against the traditional role of women and men, and promoting a life against traditional family and marriage (Ozkazanc, 2020). Moreover, for LGBTI+ communities, the

[15] https://twitter.com/ttbtok/status/1671490165599092741

same narrative constructs an oppressive discourse about them as “people whose existence is deemed a threat to humanity, civilization, and the order of God” (Ozkazanc, 2020).

In this social context, medical practice and training can not be expected to remain distant from the state narrative. On the contrary, the increasingly hostile attitude and environment against feminist and queer movements escalate discriminatory practices against women and queer people in medical practice. We can see the discriminatory and exclusionary practices against women and queer people in medical practice in the example of the dismission of a trans women physician from the profession. Although she got a positive result from the case regarding her suspension, her personal life was prosecuted in the name of defending and protecting “public morality” and the court found the decision to bar her from civil service lawful. After taking this decision to a higher court, the dismissal from the profession was found unlawful based on the principle of privacy of personal life. She emphasized that the complaints about her personal life were unrelated to her career and were directly related to transphobia and homophobia in Turkey. Before the legal process, she was already fighting against systematic mobbing and oppression in her personal and professional life. Her ambition and political struggle during the legal process allowed her to continue the profession.[16]

Lastly, in the LGBTIQA+ Medical Students’ Collective workshop, they created different teams dealing with various problems in medical practice and profession. The subjects include intersex health, trans health, medical violence, inclusionary and holistic perspectives in the medical curriculum, and so on.[17] In an interview with a collective member, they stated that the need for organizing this collective arose from the intersecting experiences of being both part of the LGBTIQA+ community and medical students and facing discriminatory practices

[16] https://sendika.org/2023/07/doktor-larin-kayatasin-meslekten-men-cezasinin-hukuka-aykiri-olduguna-ve-goreve-iade-edilmesine-karar-verildi-688758/
[17] https://kaosgl.org/haber/lgbti-tip-ogrencilerinden-orgutlenme-ve-strateji-calistayi

while seeking healthcare due to being part of the queer community. This collective addresses the challenges of discrimination, violence, and exclusion, including being denied medical treatment based on their identity. They also aim to tackle issues within medical education, where LGBTI+ topics are largely absent from the curriculum. They strive for an equal and accessible healthcare system for all, pushing policy changes, psychosocial support for members, and financial aid for marginalized medical students. They are planning both short-term and long-term initiatives: workshops, gatherings, and resource sharing to promote LGBTI+ health awareness among medical students and practitioners.[18]

4.4. Conclusion

In this chapter, I attempted to show the communal and political practices of women and LGBTI+ medical students to challenge and fight against the traditional gender structure in medical school in Turkey. Creating an informal solidarity network through which women and LGBTI+ medical students get information about specific specialties in a given institution and specific senior male professors who act aggressively and hostile to medical students was the first strategy enacted by medical students, especially my interviewees as interns. Constructing feminist and queer organizations for solidarity and fighting against patriarchal norms, habits, and practices was the second strategy enacted by medical students and practitioners.

This last chapter shows us how subjects bring out resistance and solidarity mechanisms to change the existing gender structure enforced by seniority structure, hierarchy, and societal rules and norms. In Chapter 2, I argued that critical analysis of the seniority structure would enable us to grasp how it (re)produces and normalizes the gendered medical culture and unequal power relations, diffusing everyday relations in surgical training. The specifics of power relations showed how the seniority structure was indispensable to the construction of

[18] https://sivilalanarastirmalari.org.tr/2023/04/28/lgbtiqa-tip-ogrencileri-agi-ile-roportaj/?_thumbnail_id=4895

gendered discourses and practices. Then, throughout the chapters, I demonstrated how the seniority structure and the gendered hierarchies it enforced contributed to the everyday inequalities and exclusions for women in surgical training. In this chapter, we see that women and LGBTI+ medical students oppose both the seniority structure, in other words, the traditional structure of medical education, and gendered hierarchies. We see that gender non-conforming practices of medical students, especially the LGBTIQA+ Medical Students' Collective's, problematize the social and cultural preoccupations of medical knowledge system. Their efforts expose the ambiguities and uncertainties in medical knowledge and they show that their existence can not be denied through social and cultural choices biomedicine makes in the name of "objective" and "natural" science. The "tenaciuous" assumptions of biomedicine, based on the binary gender system, excluding, for instance, intersex bodies or trying to normalize them, are brought to the surface by the subversive practices of medical students. As Biehl and Locke (2010) emphasizes, the existence and subjectivities of women and queer medical students are "as much about swerves and escapes as about determinations" (p. 335) and cannot be squeezed in the normative framework of biomedicine.

CHAPTER 5: CONCLUSION

Throughout this thesis, I wanted to expose the gendered conventions, rules, and norms in surgical training in Istanbul. It is a well-known sexist assumption that women are not born to be surgeons, but men are. When we talk about something related to surgery in a conversation, our gendered biases assume the gender of a surgeon automatically as a man if we do not make a conscious effort to *unlearn* what we came to know in a patriarchal society. To *unlearn* these gendered assumptions, I deconstructed the gendered practices and discourses in surgical training to grasp the details of why there was little or no change in the organization of surgical specialties.

At first, I went to my interviewees with the expectation that they would tell me how bad things were in surgical specialties regarding gender discrimination, sexual harassment, and violence. However, I came across the fact that, at least in the universities I conducted my research, gender awareness was higher than I thought. The initial answers of my interviewees were more optimistic than I expected. However, when we dwelt into discussing the subtle ways of gender discrimination and inequality, it became clear that gendered power relations persisted in different ways in the lives of women in surgical training. In this context, I had to critically engage with the seemingly friendly and inclusive acts and practices to understand how gendered they were.

While wrapping up my thesis, I came across a news titled “Female surgeons sexually assaulted while operating” in the UK on BBC News.[19] Journalists have spoken to women who were sexually assaulted in the operating room after a report on sexual harassment in surgery and surgical training had been published in the British Journal of Surgery. The report was shocking for some, but nothing is new or surprising for women surgeons worldwide. As the

[19] https://www.bbc.com/news/health-66775015

news also indicated, this was surgery's "open secret" where, according to the study,[20] nearly two-thirds of women surgeons who participated in the survey reported being the target of sexual harassment. And one-third of them had been sexually assaulted by colleagues, primarily seniors, in the past five years. Moreover, women say they do not trust the institutional mechanisms and lack confidence that the NHS (the National Health Service, UK) will take any action. Therefore, in addition to the psychological, physical, and professional trauma and weight of being sexually assaulted, they fear reporting the incidents will damage their careers and remain silent.

I also came across the tweets of a woman ex-neurosurgery trainee on Twitter, who wrote her experiences during the surgical training. She shared that she was told at the time, "It is just the culture," "Oh, they are always like that," "Oh, he is harmless," and also the other classic, "It is only a joke." What strikes me, but also something that I am not unfamiliar with, is how she questioned herself during that time. She says, "So probably out of a combination of denial, self-preservation, and self-doubt, I tried to convince myself it was some sort of messed up rite-of-passage. Or maybe I was just too serious or uptight?"[21] Her tweets made me think that this self-questioning was part of our lives, as perpetrators worldwide always try to blame us when we criticize their acts and deeds. It becomes women or any other oppressed group who "exaggerate" the so-called normal life incidents and "spoil" the fun. That is why they call out those who voice injustices "killjoys." "It is just the culture" and "Oh, they are always like that" are not specific to surgical training or medical school. It is in every sphere of our lives, in every academic discipline, or in the TV and film industry, as we have seen in the #MeToo

[20] I could not reach the full-text version of the study as it was highly charged. My understanding of the situation and the numbers included were from the news.
[21] https://twitter.com/MsBethanJ/status/1701654168216178938

movement, where women actors, directors, and other celebrities spoke out about sexual assaults of powerful and wealthy male figures of the industry.

At the ethical and political level, it is obvious why we should continue studying gender in academia, as my reflections above show. However, I was asked to carry my attempt to deconstruct gendered discourses and practices to a theoretical level. I was asked why we must read the seniority structure through a gender lens. What do gender theories tell us about the hierarchical relations (re)produced by the seniority structure? How and why does the hierarchical education system in surgical training become a legitimation ground for sexism and gender-based discrimination? These questions were not to uncouple theory and feminist practice. Or they were not the questions of a guy who is "overwhelmed" by feminist concerns and knowledge production as we "always" talk about gender and "spoil" the fun. Instead, they are to understand and reaffirm the necessity of more feminist theory and theorization in academia.

Drawing inspiration from Scott's conceptualization of gender as "a useful category of historical analysis" (1986), my answer to the question of why we must read and understand the seniority structure through a gender lens is that power relations in all aspects of social life cannot be understood without a gender lens. All adjectives and characteristics attributed to femininity and masculinity continuously constructed as "fixed" and "natural" serve to give meaning to and consolidate unequal power relations. As Scott argues, "gender is a primary way of signifying relationships of power" (p. 1067). Thus, it is one of the "primary fields within which or by means of which power is articulated" (p. 1069).

Interviews reveal that gendered assumptions of senior male professors structure their perception and understanding of whether a woman is a good fit into surgical departments, mostly without knowing anything about a given woman's personal characteristics and professional skills. Even the decisions of some women surgeons regarding not choosing

surgical specialties unrelated to their gender identity were interpreted by others through their "womanhood." For this matter, Scott argues that gender-related ideas shape how we perceive ourselves, the other, and the way society is organized, both in tangible and symbolic terms. When these gendered benchmarks establish how power is allocated, "gender becomes implicated in the conception and construction of power itself" (p. 1069). That is why hierarchical relations and the seniority structure are gendered from the beginning. Therefore, we must deconstruct them not only to show how they legitimize unequal power relations but also how they reconstruct gender itself and fixate it "to decode meaning and to understand the complex connections among various forms of human interaction" (p. 1070).

Overall, this thesis provided an analysis of the gendered structure of surgical training in Istanbul. This gendered structure intertwined with the seniority (re)produces, maintains, and normalizes gendered hierarchies of power and domination in surgical training. It affects and shapes women medical students' career choices and advancement and leads them to non-surgical specialties as they cannot find a place for themselves in surgical specialties. I hope my research contributes to our understanding of gender relations and inequalities in surgical training in Turkey, through which gender awareness and equality might increase. I also hope that my attempt to understand women's experiences in surgery can reach out to medical students, especially all the feminist souls in medical school who want to make a change and become powerful and successful surgeons in the future.

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