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Gender-Related Beliefs and Roles Among Romanian Medical Students and Healthcare Professionals: A Qualitative Study

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Abstract

Gender role beliefs have been found to play a role in healthcare interactions and outcomes, although research is scarce in contexts where gender-diversity trends increasingly challenge enduring traditions, as is currently the case in Romanian society. This study explored reported gender-role beliefs and behavioural patterns among fifty Romanian participants involved in medical training and practice, representing a heterogeneous socio-professional spectrum rather than a uniform academic group (aged 20–52 with different personal circumstances and clinical employment). Written and oral reflections on gender role axioms widely known in Romania were assessed using an interpretative phenomenological approach. Results indicated strong endorsement of traditional beliefs—such as male authority and female domestic responsibility—while participants also reported behaviours and life situations inconsistent with those beliefs, including women serving as primary earners, engaging in advanced studies, and balancing multiple roles, and men in caregiving professions. This apparent belief–practice gap, not recognised as such by participants, suggests limited prior reflection on gender issues and potential tensions between pressure to conform to inherited sociocultural norms and evolving personal and professional realities. These findings raise questions regarding possible implications for clinical care, as gender-role assumptions may influence communication, rapport, and preparedness for engaging with gender-diverse patients and peers. They suggest a need for gender-diversity education, reflexivity training, and cultural competence development across undergraduate curricula, continuing education, and workplace training. The key insight of the study is that traditional gender representations can persist unexamined alongside changing behavioural realities, warranting further investigation of their relevance for healthcare education and practice.

Keywords: gender-role beliefs; gender stereotypes; gender diversity; medical education; qualitative research; Romania



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1. Introduction

Gender diversity and nonconformity are increasingly present and visible in contemporary society. Initially more evident in the United States and Western Europe, it is now well documented globally [1–5]. Individuals with gender nonconforming identities sometimes report negative experiences when seeking medical care, which may be attributed to limited professional competence but also to discriminatory and stigmatising behaviours rooted in longstanding cultural intolerance. Healthcare professionals should receive structured education in gender-diverse and transgender health in order to ensure equitable and competent patient care, according to some authors [6].

The concepts of sex, gender, and gender roles have evolved across historical and cultural contexts, with gender roles understood as interdisciplinary constructs informed by culture, ethnicity, family, and community-transmitted practices that become social norms through reinforcement and sanction [7,8]. As gender roles influence relationships and expectations, persistent traditional stereotypes such as male authority and female caregiving continue to shape personal development and professional opportunities, particularly for women [9]. Strict adherence to such roles may foster intolerance towards gender nonconforming individuals, limiting their social acceptance, integration, and access to services.

Stereotypes are closely linked to gender as a cultural construct grounded in socially defined norms of sexual differentiation and behavioural appropriateness. They are reinforced through family socialisation, education, media, and religious frameworks, which are all vectors of conformity pressure and perpetuation [8–12]. Also, gender stereotypes seem to be internalised early in life and reinforced through social conformity pressures. Children show greater reluctance and embarrassment when engaging in gender stereotype-violating roles, which highlights even more the influence of social norms on gender-related behaviour [13]. Historically, gender differences have often been framed as natural or religiously sanctioned, reinforcing patriarchal social structures and subordinate roles for women [14,15]. Cultural traditions, therefore, continue to shape gender role attribution, with patriarchal ideologies involved in the normalisation of gender-based inequalities [7,11]. In Romania, such norms appear deeply embedded, while international evidence links religious fundamentalism to low acceptance of nonconforming sexual orientations and higher levels of homophobic attitudes, particularly among men [16].

Since the 1970s, rigid gender role stereotypes have been shown to constrain personal development and psychosocial well-being, prompting growing criticism of patriarchal models and calls for structured gender-diversity education. However, teaching on transgender healthcare remains limited, and gender stereotypes persist within healthcare professions, where nursing is frequently seen as a feminised occupation and traits culturally coded as masculine are often valued above those associated with femininity [10,14,17–21]. Although women constitute the majority of the healthcare workforce, they remain underrepresented in senior leadership roles and face elevated risks of burnout, reflecting enduring gendered expectations that influence professional training and career progression [18,22,23].

Empirical evidence further indicates that gender stereotypes play a role in the evaluation of medical students and healthcare professionals, with men more likely to be perceived as leaders and women as caring or collaborative, despite comparable career aspirations [24–27]. Pressure to conform to gender norms can steer career choices, training experiences, and workplace integration, contributing to workforce imbalances and professional attrition, particularly among men in nursing. While gender roles remain socially foundational [28,29], they are culturally contingent and evolving, challenging biologically deterministic assumptions [30]. Although greater role diversity has been associated with improved psychological well-being, persistent inequalities and rigid expectations can ad-

versely affect mental health, especially among women, while higher educational attainment and more flexible gender role frameworks correlate with better mental health outcomes and quality of life [17,31–35]. Researchers have also linked education supporting diverse gender roles to improved overall well-being [17,31,36].

Within healthcare, gender stereotypes and associated sociocultural axioms may function as internalised cognitive frameworks that contribute to professional behaviour and practice [9]. In interactions with gender-diverse patients, they may influence clinicians' attitudes, empathy, and communication, potentially leading to misinterpretation of patient needs and underdiagnosis, or to the patients' avoidance of healthcare services due to anticipated stigma. International scholarship has already documented the role of the clinician–patient relationship in the health outcomes of gender-diverse populations, as gender diverse patients have specific healthcare needs [6,12,37–40]. Simultaneously, such norms may intervene in professional hierarchies and career trajectories. This dual influence, affecting both the clinician–patient relationship and the professional opportunities of healthcare workers, can contribute to the perpetuation of structural inequalities and institutional environments that can be insufficiently inclusive of increasing gender diversity.

In Romania, scientific data are scarce regarding the scale and quality of healthcare for gender-diverse individuals, or regarding the representation and experience of gender diversity in the healthcare workforce. We may hypothesise that limited social acceptance, lack of awareness, or suboptimal conditions for gender-relevant procedures may be among the likely challenges. This highlights a need for both culturally relevant research and initiatives toward social inclusion and professional readiness. In Romanian society, heightened conformism linked to deeply upheld religious and spiritual beliefs may amplify resistance to increasingly visible gender nonconformity trends previously treated as taboo. In the public space, we are witnessing unprincipled weaponisation of such tensions for political gains; however, in healthcare, clinicians need to be prepared to care for gender diverse patients with adequate understanding and compassion.

High-quality care thus requires the recognition and acceptance of gender diversity, supported by empathy and professional competence [41,42]. Healthcare providers' perceptions of their own gender roles are important, as they directly shape attitudes and behaviours towards patients with diverse gender identities. Within Romania's still largely traditionalist society, medical professionals must adapt conceptually and psychologically to caring for gender nonconforming patients, requiring flexibility and targeted training. In our study, we aimed to examine general stereotypical perceptions of gender-assigned traits among (aspiring) medical practitioners as a precursor for relating to non-conforming gender roles in others (patients, peers) and a basis for the study of gender-sensitive medical care in Romania.

2. Materials and Methods

The study began with the identification of open-access/archived systematic reviews published in English during 2020–2023, and indexed in the international research databases PubMed and ScienceDirect. These were chosen based on their complementarity in database scope, indexing strategies, and disciplinary coverage. ScienceDirect includes multidisciplinary content spanning the social sciences and humanities, whereas PubMed primarily indexes biomedical literature, which allows for more targeted retrieval of interdisciplinary sociocultural constructs such as gender roles in medical settings. The search was conducted in November–December 2024 using the terms “gender role,” “traditional gender role,” “gender defined medical care,” “transgender,” “transgender healthcare,” and “gender non-conformity.” Initial results were filtered by combining two or three search terms. Abstracts were screened and relevant full texts analysed.

The emerging themes were used to construct an interview-based survey aimed at a convenience sample of fifty medical students in the same undergraduate programme at a top-ranking Romanian medical university. They were recruited from the same year of study. Inclusion in the study was based on voluntary agreement to participate, and students were enrolled as a convenience sample rather than through demographic-targeted recruitment. Written informed consent was required; participants were also informed of their right to withdraw from the study at any point. Confidentiality and anonymity were established and maintained, as the interpretative phenomenological approach was used to identify general attitudes and stereotypes previously documented in the literature.

Data were collected in Romanian through written free-text responses and oral in-depth interviews exploring traditional cultural stereotypes and social axioms regarding gender roles. These tools enabled participants to respond in their own words, producing rich, detailed accounts. All researchers had medical expertise. The study sought qualitative rather than statistical representativeness, focusing on psycho-behavioural traits relevant to professional conduct in healthcare. A secondary analysis compared the participants' psychological traits with those in published Romanian data (e.g., conformism, religiosity, obedience to ecclesiastical dogma) to examine influences on receptivity to gender diversity. Participants were invited to comment on stereotypical statements, social imperatives, and norms (e.g., *you must...*, or *it is good to...*). Their responses were then assessed in relation to demographic and professional characteristics (e.g., environment, marital status, religious practice, education level, openness to debate).

The discussed items are as follows:

- I. The man is the head of the family;
- II. The man must ensure family security;
- III. The woman takes care of the household and children;
- IV. Women should obey their partner/husband;
- V. A woman ought to get married;
- VI. It is better to remain in an unsuccessful marriage than not to marry at all.

The analytical process followed an iterative interpretative phenomenological approach based on Paul Collaizi's seven-step framework. Initial familiarisation was achieved through repeated reading of interview transcripts and written responses. Meaning units were subsequently identified and grouped into preliminary codes reflecting current attitudes, symbolic expressions, and sociocultural representations related to gender roles and gender nonconformity. Codes were progressively refined through constant comparison and clustered into broader thematic categories.

Participant outputs were independently reviewed by two researchers with clinical and academic expertise to ensure analytical validity. Differences in coding interpretation or thematic allocation were discussed through peer debriefing until consensus was reached. Reflexivity was maintained throughout the analysis by acknowledging potential researcher assumptions and continuously reevaluating interpretations in relation to participant narratives and contextual factors.

Thematic saturation was considered achieved when no substantially new thematic patterns or conceptual categories emerged from successive interviews and written responses. Member checking was additionally used to confirm the consistency and interpretative validity of the identified themes.

The study adhered to three international frameworks for qualitative research to support methodological rigour and transparent reporting: SAGER for integrating the sex/gender dimension [43]; SRQR for structured reporting of context, sampling, and analysis [44]; and COREQ for documenting the research team, reflexivity, data collection, saturation, and quotations [45]. These ensured methodological rigour and transparent reporting.

3. Results

The literature search yielded substantially more records in ScienceDirect than in PubMed, particularly for broad terms such as “gender role” (6115 versus 36 results) and “traditional gender role” (2651 versus 2 results). The initial search on ScienceDirect also produced 2852 results for “gender defined nursing” and 306 results for “transgender”.

3.1. General Demographic Characteristics

The fifty medical students enrolled in the study were aged 20–52 and mostly women (90%). Notably, seven women were aged over 40 (see Table 1).

Table 1. Age distribution of study participants (in years).

Age Group	20–29	30–39	40–49	≥50
Women	25	13	5	2
Men	2	1	1	1
Total	27	14	6	3

Most participants lived in urban areas (92%, including all five men), with only four women from rural settings. With regard to marital status, 53% of the women were married, particularly in the 20–39 age group; others were single, divorced, or in consensual partnerships, and only one woman was widowed (see Table 2). Twenty-eight women had children and five were pregnant at the time of the survey. Two of the male participants under the age of 29 were single, another two were married, and one was divorced (aged 40–49).

Table 2. Marital status among female respondents.

Marital Status	0–29	30–39	40–49	≥50	Total
Married	11	10	2	1	24
Consensual relationship	3	1	0	0	4
Divorced	2	2	3	0	7
Widows	0	0	0	1	1
Single	9	0	0	0	9

Fifteen participants were high-school graduates without prior professional experience, while thirty-three (66%) were healthcare professionals, mostly married nurses seeking a medical degree. Five were employed in intensive care, three each in surgery, functional explorations, and ambulance services, two each in infectious diseases and paediatric pneumology, one each in psychiatry, transfusion, emergency, diabetes, neurology, and palliative care. Two participants were employed in non-medical settings and had the intention of specialising in healthcare.

Regarding religious affiliation, all participants identified as Christian, with thirty-nine declaring Orthodox faith (78%), and eleven identifying as Protestant and Neo-protestant–Pentecostal, Baptist, and Adventist.

3.2. Qualitative Analysis of Participants’ Open Interpretation of Studied Social Constructs

All respondents were familiar with patriarchal norms placing the man as *the head of the family* (or *the head of the woman* as the biblical version), and only three participants aged 20–29 did not comment. Overall, 74% of respondents gravitated toward conformity and expressed varying degrees of agreement.

Twenty-three participants (46%), including 44.4% of all female respondents, expressed agreement in principle and provided justifying arguments. By age group, this included

nine women aged 20–29 (four married, one in a consensual relationship, four single), eight married women aged 30–39, and three married women over the age of 40. Three of the five men also agreed (one single, one married, one divorced, aged 20–49) (see Tables 3 and 4).

Table 3. Agreement with Item I (The man is the head of the family) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	9	8	2	1	20
Men	1	1	1	0	3
Total	10	9	3	1	23

Table 4. Disagreement with Item I (The man is the head of the family) by marital status and age.

Marital Status	20–29	30–39	40–49	≥50	Total
Married	1	1	0	1	3
Consensual union	1	0	0	0	1
Divorced	2	1	0	0	3
Single	3	0	0	0	3

Married women were more likely to endorse patriarchal views. These participants were professionally active and not economically dependent on men, yet appeared unaware of or unconflicted by the non-traditional aspects of their lived gender roles. Four of the seventeen married women aged 20–39 (23%) and another four single women strongly endorsed the axiom, suggesting the continuing influence of cultural and religious traditions. The responses of the older women reflected a more traditionalist upbringing shaped by Romania's socio-political background prior to the fall of the Communist regime in 1989; although not directly exposed to the same conditions during childhood, younger women also demonstrated similar strong cultural and religious adherence.

Among the male participants, three expressed patriarchal views irrespective of marital status, such as in these examples of agreement: “Men have always had exclusivity and freedom, and we have recognized these rights for them because our mothers and grandmothers did the same.” “The man is the head. The woman can offer advice, but he makes the decisions on all matters.” “A man's primacy in marriage manifests as a duty of love, service, and sacrifice for the sake of his wife.” “Man was not created for the woman, but the woman was created for the man.” “[The woman's] submission is a necessity for a harmonious life,” “Man was created first and the woman was created for him.”

In contrast, categorical rejection of the patriarchal axioms was expressed by 19% of all women (aged 20–39, including two married, one in a consensual relationship, two single, and three divorced), as well as by two of the five men. Not all were employed. Their responses included disapproving comments such as: “The custom that the man is the head of the wife encourages men to be dominant and women to be obedient [...] placing men and women on different positions from the start, giving men total authority over women, who are thus oppressed, and thereby [...] encourages men toward a false masculinity.” “This saying can contribute to unbalanced couple relationships.”

In fourteen cases (28%), more nuanced positions were argued, accepting male responsibility for family order rather than absolute authority. In the words of one participant, “the role of head of the household can be perceived by men as a burden and can create pressure to make decisions, ensure the well-being of their families and meet the expectations placed upon them.”

Other patriarchal social norms elicited mostly agreement as well, i.e., *man must support his family* and *man must ensure family safety* (see Table 5). While twelve respondents disagreed, thirty-five women and three men commented favourably: “These statements were

established by God for our own good.” “These divine instructions would be of real benefit for us.” Notably, most of the women who agreed were aged 20–39. Their reactions were along these lines: “The man has the great responsibility to provide what is necessary for a decent life and to make wise decisions for a better future.” “The man ensures the wellbeing of the family”.

Table 5. Agreement with Item II (Man must ensure family safety) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	20	11	3	1	35
Men	1	1	1	0	3
Total	21	12	4	1	38

This level of agreement reflects both the predominance of traditional attitudes among the younger participants and the simultaneous enactment of complex gender roles. While healthcare work, nursing in particular, has been historically associated with women, academic advancement and higher education have been traditionally viewed as male domains. Female respondents appeared not to recognise that, by pursuing higher studies and professional advancement, they were already diversifying their roles, no longer relying on the cultural stereotype of male financial support, but, instead, engaging in voluntary, non-traditional forms of empowerment. For men, nursing careers transcend the traditional male roles.

Next, we report on the counterpart socio-cultural stereotypes focusing on women’s role, studied through the responses that participants gave to the statements *Women care for the household and children* and *Women are responsible for children’s education*. These were endorsed by 64% of respondents (twenty-nine women and three men—see Table 6), as illustrated by this remark: “A wife’s role is to raise children well; no man can care for them the way a mother does”.

Table 6. Agreement with Item III (Women care for the household and children) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	11	12	4	2	29
Men	1	1	1	0	3
Total	12	13	5	2	32

Varying degrees of disagreement were noted in fifteen cases, mostly women aged 20–29 (also two older women and two men) (see Table 7). Where positions departed from the conventions of the input statement without leaning in the opposite direction, they were still coded as disagreement: “This concept can also affect the parent–child relationship, as it shaped the way men and women share responsibilities in raising and educating their children”. In total, twenty-eight women and two men who were also parents described that, in their families, both partners took care of the children and participated in household chores. While most women who endorsed these axioms were married, five unmarried younger women disagreed, illustrative of the contemporary diversification of gender role attributes within family life. Three women did not express an opinion.

The analysis also assessed reactions to common normative phrasings (*you should*. . . and *it is good to*. . .) used in expressing beliefs, such as *women should obey* their partner/husband. Participants who agreed justified their position primarily in terms of respect for their partner or husband, extending this to the notion of obedience (see Table 8), as illustrated by these interview excerpts: “Wives must submit to the authority of their husbands.” “The point is that we must not do anything that might upset our husband.” “Saint John

Chrysostom urges women to fear losing the love of their husband, who seeks to bring her joy and contributes to her salvation." "Let us not do anything we would not want our husband to find out about." "This is the fear that preserves the unity of the marriage".

Table 7. Disagreement with Item III (Women care for the household and children) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	11	1	1	0	13
Men	1	0	0	1	2
Total	12	1	1	1	15

Table 8. Agreement with Item IV (Women should obey their partner/husband) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	11	3	1	0	15
Men	2	0	0	0	2
Total	13	3	1	0	17

Such perspectives were expressed by fifteen women, of whom eleven aged 20–29 and four aged 30–49, as well as by two of the five men. The other male participants appeared reluctant to give their opinions in the context of their interviews. Overall, the concept of obedience was more strongly identified among women aged 20–29, which might originate in life experiences and influences that were not elicited or reflected in the interviews.

The notion of female obedience to the male partner was rejected by thirty women and two men across all age groups and marital statuses, though mostly under the age of 40 (see Table 9), as reflected in these quotes: "I don't think it's healthy to accept the idea that if he hits you, he loves you, and that you should be afraid of the man." "If the fear between a daughter and her parents hadn't been created from the start, it would be absurd for a woman to fear the man she chose to marry." "Nowadays, those customs are a thing of the past, because there is equality between men and women." "Submission and obedience in a relationship must come from love, not from fear". One male participant did not provide a response.

Table 9. Disagreement with Item IV (Women should obey their partner/husband) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	14	10	4	2	30
Men	0	1	1	0	2
Total	14	11	5	2	32

To further explore conformity to gender role stereotypes, two more social axioms were discussed: *A woman ought to get married*, and *It is better to remain in an unsuccessful marriage than not to marry at all*. The first was viewed favourably by 78% of respondents (thirty-five women and four men—see Table 10). One man did not comment.

Table 10. Agreement with Item V (A woman ought to get married) by sex and age.

Age Group	20–29	30–39	40–49	≥50	Total
Women	16	12	5	2	35
Men	1	1	1	1	4
Total	17	13	6	3	39

Overall, twenty-one of the women who agreed were married (60%), suggesting that married status might be associated with gender role conformity in this cohort. However, the granular data paints a more diverse picture: among the sixteen women aged 20–29 who agreed, nine were married, one was in a consensual relationship, two were divorced, and four were single. Of the twelve women aged 30–39, nine were married and two divorced, while three of the women above the age of 40 were married and three divorced. “It is not good for a woman to be single,” one said. In contrast, nine women aged 20–29 and one aged 30–39, mostly single, disagreed, i.e., “Women have the ability to work, the right to express their opinions, and the right to be independent”.

Regarding reactions to whether *it is better to stay in an unsuccessful marriage than not to marry at all*, twenty-one women were in agreement, i.e., “Children need a father figure.” Of them, ten were aged 20–29, eight were 30–39, and three were ≥ 40 years; sixteen were married. All respondents who endorsed this axiom either had children or were pregnant at the time of the study. In contrast, twenty-two women and all five men disagreed, including eight married women who had children. “I don’t think it’s right for us to accept a situation where women are devalued, treated as inferior to men, and denied the freedom to live their lives without fear,” one said. Two respondents were undecided.

Overall, female students appeared more divided in their views toward marriage: some upheld it as a necessity regardless of quality—a deeply stereotypical view—while others demonstrated nonconforming attitudes toward traditional gender roles. All twenty-eight women and two men who had children mentioned the father participating in childcare and household tasks. These so-reported domestic realities only partially aligned with stereotypes assigning such responsibilities exclusively to women. Traditionally, women were expected to assume domestic work while men served as breadwinners; however, contemporary norms increasingly reflect more flexible arrangements, even though certain tasks remain culturally gendered.

The results of the qualitative analysis can be summarised as follows (see Table 11):

Table 11. Overall agreement/disagreement with the studied axioms.

Axiomatic Statements:	Agree	Disagree	Nuanced Acceptance	Did Not Know or Comment
I. Man is the head of the family.	23 (46%)	10 (20%)	14 (28%)	3 (6%)
II. Man must ensure family security.	38 (76%)	12 (24%)	0	0
III. The woman cares for the household and children.	32 (64%)	15 (30%)	0	3 (6%)
IV. Women should obey their partner/husband.	17 (34%)	32 (64%)	0	1 (2%)
V. A woman ought to get married.	39 (78%)	10 (20%)	0	1 (2%)
VI. It is better to stay in an unsuccessful marriage than not to marry at all.	21 (42%)	27 (54%)	0	2 (4%)

The highest rates of acceptance of cultural stereotypes related to gender roles were recorded for items II, III, and V. Responses reflect gender-stereotypical conceptions consistent with cultural traditions across many societies, including Romania. They indicate strong adherence to traditional gender roles and paternalistic views among the respondents, often in contrast with the emancipatory pursuit of a medical degree and career. Closer analysis of item I data further supports this finding.

Conversely, the lowest levels of agreement were observed for items IV and VI, where responses indicate rejection, resistance, or reluctance toward conceptions of female subservience, representative of non-discriminatory values in modern education. The coexistence of high conformity to some patriarchal norms with low acceptance of others reveals an unresolved ideological mix, insufficiently examined and internalised by participants.

The in-depth interview approach allowed for the stereotypically mediated conceptions of gender roles to be expressed in the context of personal and professional life choices, also described by the participants. Many of the women combined multiple roles—married with children, employed in healthcare, managing household and childcare responsibilities, while simultaneously pursuing higher education and career advancement. Circumstances were diverse, with some female respondents being single caregivers, divorced mothers continuing their studies, women in consensual relationships developing parallel careers, or professionals transitioning from non-medical to medical fields. Moreover, gender nonconforming attitudes were identified not only through explicit or partial disagreement with patriarchal axioms, but also in the reported pursuit of advanced studies accompanied by reduced domestic engagement, single parenthood, women as family providers, male nurses, men involved in childcare and household tasks, etc.

The four major orientations emerging from the data are:

- High conformity to traditional stereotypes (agreement with all axioms), observed in eight cases (16%);
- Partial conformity (agreement with items I, II, III, V), twenty-nine cases (58%);
- Nuanced positions of limited acceptance (e.g., item I), fourteen cases (28%);
- Non-conformity (rejection of all axioms), four cases (8%).

The inconsistencies noted between conceptualised roles and attitudes toward traditional cultural stereotypes, on one hand, and actual professional and personal choices and behaviours, on the other hand, are another significant finding of the study.

4. Discussion

This study reveals psychological and sociocultural discrepancies between culturally inherited gender role beliefs and reported behaviours among individuals engaged in medical training and clinical work in Romania. Although participants frequently endorsed traditional gender role axioms—particularly male authority and female domestic responsibility—their lived experiences often contradicted these views. In our study group, women commonly acted as primary earners, pursued advanced education, and balanced multiple responsibilities, while men worked in caregiving professions traditionally perceived as feminine. This incongruence may result from limited reflexive awareness with regard to gender roles, and it may contribute to the persistence of unconscious gender bias [8–10].

The study group was heterogeneous in terms of age, professional exposure, life experience, family status, caregiving responsibilities, and levels of clinical experience, spanning participants from early adulthood to midlife and from aspiring to employed healthcare professionals. This diversity is important for capturing a range of cultural and spiritual perspectives on gender roles among individuals engaged in medical training and healthcare practice. Although all identified as Christian, variations in social background and religious affiliation contributed to meaningful intra-group diversity. This heterogeneity may strengthen the interpretative richness of the otherwise speculative findings, allowing gender role beliefs to be examined across intersecting personal, professional, and cultural contexts rather than within a homogeneous student cohort.

4.1. Breadth of Literature and Methodological Refinement

The initial literature search yielded a substantial number of records, particularly within the broader database ScienceDirect. This reflects the interdisciplinary scope of gender scholarship, encompassing psychology, sociology, education, nursing, and political science alongside biomedical research. Concurrently, PubMed—centred on clinically oriented and MeSH-indexed literature—returned considerably fewer results for identical search terms.

This broad vs. narrow retrieval does not equate to analytical relevance; many publications addressed abstract theoretical models, different cultural settings, or non-medical populations. Applying predefined inclusion and exclusion criteria focusing on medical education, sociocultural relevance, internalised gender norms [9,10], and implications for professional conduct substantially narrowed the corpus. Duplicate entries, unavailable full texts, and studies lacking a direct connection between gender role beliefs and healthcare practice were excluded. This transition from volume to specificity underscores both the expansiveness and fragmentation of existing scholarship. While gender role research is well established internationally, investigations directly addressing Romanian medical training and professional socialisation remain limited. The refinement process, therefore, reflects methodological selectivity rather than thematic insufficiency and supports the relevance and originality of the present study within a relatively underexplored regional and professional setting.

4.2. Cultural Traditionalism, Generational Ambivalence, and the Belief–Practice Gap

For the medical students in the study group, findings indicate a tension between a persistent, historically patriarchal cultural–religious framework [8] and contemporary international discourses on gender equality [46]. This manifests not as categorical resistance or endorsement, but as ambivalence. Participants often affirmed traditional axioms—particularly positioning men as authority figures and women as primary caregivers—while simultaneously pursuing life trajectories that diverged from these expectations. The intergenerational transmission of gender norms through family, religious institutions, and community networks remains robust, even among highly educated individuals undergoing medical specialisation. Younger respondents (20–29 years) exemplified this complexity: they expressed attachment to inherited norms as well as comparatively greater openness to questioning or contesting these norms. Generational transition within the healthcare workforce thus appears incremental and uneven, shaped by the coexistence of inherited socialisation and exposure to pluralistic academic environments.

A significant observation concerns the disjunction between explicit attitudes and everyday practice. Although many respondents expressed reservations regarding gender nonconformity, they seldom interpreted their own behaviours as traditional gender roles. Experiences such as divorce, non-marital partnerships, women’s sustained professional advancement, and men’s involvement in caregiving were rarely framed as departures from traditional norms. This may be a pattern of persistent internal sociocultural schemas that remain cognitively influential even as behavioural realities evolve [16,21]. Women increasingly occupy demanding professional roles while holding domestic responsibilities, whereas men enter occupations historically perceived as feminine without necessarily challenging their masculine identity frameworks. Together, these findings suggest that diversification of gender roles has already been occurring in practice, although not always accompanied by explicit analytical recognition.

Given the exploratory nature of this qualitative study, such observations should be interpreted with caution rather than claiming demonstration of bias or limited self-awareness. Interpretations regarding attitudes toward gender diversity should be understood as context-dependent tendencies emerging from participants’ narratives and socio-cultural positioning. Further research using validated qualitative and quantitative approaches is warranted.

4.3. Professional Socialisation, Ethical Deliberation, and Clinical Implications

In our study, professional experience influenced how participants approached gender-related questions. Students without employment experience expressed greater hesitancy

and occasionally relied on moral or spiritual reasoning in place of professional analysis. By contrast, clinically active participants, especially in acute care settings, demonstrated clearer role differentiation and pragmatic orientation. Nevertheless, clinical employment status did not consistently associate with a particular conceptual understanding of gender diversity or psychosocial dimensions of care [18]. Educational gaps persisted irrespective of employment status, indicating that experiential learning alone is insufficient.

An aspect that warrants further investigation concerns the potential influence of different religious and socio-cultural frameworks on attitudes toward gender roles and gender nonconformity. Although the studied sample reflected a predominantly traditional Christian context, future studies involving larger and more diverse religious, cultural, and social groups of medical students and healthcare professionals could clarify whether the observed patterns represent a more general phenomenon or are primarily associated with traditional value systems. Comparative cross-cultural approaches may also contribute to a more nuanced understanding of how religiosity, social norms, and professional identity interact in shaping attitudes toward gender-diverse individuals and inclusive healthcare practices.

In any case, the salience of religious and cultural convictions highlights potential areas of friction between personal worldviews and professional standards of healthcare. Ethical practice requires deliberate reflection on how individual belief systems intersect with obligations of impartiality and equity. Within clinical contexts, insufficient awareness of these tensions may influence professional judgement and interpersonal engagement. When implicit assumptions remain unexamined, subtle distortions and omissions in communication or interpretation may arise, particularly in encounters involving gender-diverse individuals.

4.4. Systemic Consequences for Healthcare Provision and Education

The influence of gender norms extends beyond individual cognition into organisational culture. In patient care, entrenched assumptions may subtly shape expectations regarding authority, communication style, and role allocation. Institutional valorisation of attributes stereotypically associated with masculinity may coexist with the undervaluation of relational competencies, reinforcing hierarchical asymmetries.

At a structural level, occupational stratification remains evident. Although not directly the object of this study, the concentration of women in caregiving roles and the symbolic association of leadership with masculinity contribute to imbalanced career trajectories. These dynamics are underpinned by the studied beliefs and, at the same time, they carry psychosocial consequences: cumulative professional and domestic responsibilities may heighten stress exposure among women, while men in feminised roles may confront identity tension or social scrutiny and pressure [15]. Such patterns affect not only individual well-being [33] but also institutional sustainability and team functioning.

The influence of deeply embedded gender norms within healthcare environments can be addressed through targeted institutional responses or, more systemically, through the integration of structured education on gender diversity within both undergraduate curricula and continuing professional training [6]. Effective initiatives should incorporate ethical reasoning, cultural competence, and guided self-reflection rather than solely informational content. Strengthening reflexive capacity early on may help reduce implicit bias and clarify professional boundaries, while institutional alignment with international standards of inclusivity further requires recognition of how social norms shape organisational practice.

Our findings cautiously suggest that the gradual diversification of gender roles in contemporary Romanian society should not be used as a reliable indicator of critical self-awareness and systemic adaptation among (aspiring) healthcare professionals. Moreover, the limited availability of context-specific research in the international literature underscores the need for continued empirical inquiry within Romanian society and the healthcare

system. Lastly, considering the substantial mobility of Romanian healthcare professionals in a multicultural world, supporting their self-awareness, self-monitoring, and self-regulating capacity with regard to gender identities and ideologies seems appropriate.

We acknowledge several limitations of the present study. First, the research used a convenience sample of fifty participants from a single academic institution in Romania, which restricts the generalisability of the findings. Convenience sampling introduces the potential for selection bias, as individuals who chose to participate may differ systematically in their attitudes or experiences from those who did not. Additionally, the demographic characteristics were skewed toward younger students and female respondents, which limits the scope for gender-based comparisons and may also underrepresent the perspectives of more experienced healthcare professionals. As such, participants may not accurately reflect the broader diversity of Romanian medical students, healthcare professionals, or socio-cultural contexts.

Moreover, the study relied primarily on qualitative, cross-sectional methods. While these approaches allow for in-depth exploration of attitudes and perceptions, they are inherently subject to researcher interpretation and lack the relative objectivity and replicability associated with quantitative designs. Reliance on self-reported data also raises the possibility of social desirability bias, with participants potentially tailoring their responses to align with perceived expectations. The interview setting and interviewer may also have inadvertently influenced participants' willingness to express individual views, potentially encouraging conformity, caution, or ambiguity.

Third, the analytical framework focused on predefined gender stereotypes and social axioms. Although this focus provided conceptual clarity, it did not address all relevant dimensions of gender diversity, such as intersections with ethnicity, socioeconomic status, and sexual orientation. Methodological triangulation, including standardised psychometric instruments or quantitative survey data, would strengthen validation of the qualitative findings.

Finally, the study was conducted within the specific cultural and religious context of Romania, whereas the studied international literature documents significant differences across Europe and the world. The cross-sectional design of the findings also precludes examination of how attitudes towards gender roles may evolve over time, particularly as the participants progress from medical training and transition into professional practice.

These limitations underscore the need for future research employing larger, more diverse, and representative samples, longitudinal designs, and mixed-methods approaches, capitalising on our insights to enable a reliable, nuanced understanding of the dynamics of gender role stereotypes in healthcare contexts.

5. Conclusions

The central finding of this exploratory qualitative study appears to be a belief–practice gap in relation to gender roles among the Romanian medical students and healthcare workers included in this cohort. On one hand, traditional beliefs were prevalent, as many participants openly endorsed patriarchal views of male authority and female domestic and caregiving roles. Concurrently, they also reported personal circumstances and professional paths that often diverged from these beliefs; for example, through married women's pursuit of medical education and careers, men's employment in caregiving healthcare occupations, or the sharing of domestic and childcare responsibilities. However, the lived experience of role diversification was not consistently recognised as a departure from tradition.

These findings invite consideration of whether unexamined gender-role assumptions may challenge and influence healthcare dynamics in ways that we do not fully grasp without context-specific understanding and relevant training. Exposure to gender-related

information sourced internationally does not, by itself, ensure preparedness to build rapport, communicate effectively, and deliver equitable care to gender-diverse patients, nor does it guarantee acceptance and inclusion of gender-diverse healthcare professionals. This may be especially relevant in societal contexts such as in contemporary Romania, where gender-related tensions are increasingly visible in public discourse.

While the single-centre, qualitative design of our study demands cautious interpretation, the results suggest the need for more explicit reflexive engagement with gender-role assumptions. In practice, medical and nursing curricula could include gender diversity not only as theoretical content, but also opportunities for guided reflection on personal assumptions, anti-bias training, and clinically relevant cases of adequate versus inadequate care.

To achieve this effectively, without sweeping generalisations and unverified assumptions, further research is needed on larger, more diverse participant samples across multiple institutions providing healthcare education and services. Methodologically, mixed and longitudinal designs would help clarify how gender-role beliefs develop during medical training in the presence or absence of targeted educational interventions, and how they may contribute to professional conduct and patient care.

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References

1. Bouman, W.P.; de Vries, A.L.; T’Sjoen, G. Gender Dysphoria and Gender Incongruence: An evolving inter-disciplinary field. *Int. Rev. Psychiatry* **2016**, *28*, 1–4. [[CrossRef](#)] [[PubMed](#)]
2. Oshima, Y.; Matsumoto, Y.; Terada, S.; Yamada, N. Prevalence of Gender Dysphoria by Gender and Age in Japan: A Population-Based Internet Survey Using the Utrecht Gender Dysphoria Scale. *J. Sex. Med.* **2022**, *19*, 1185–1195. [[CrossRef](#)] [[PubMed](#)]
3. Kuyper, L.; Wijsen, C. Gender Identities and Gender Dysphoria in the Netherlands. *Arch. Sex. Behav.* **2014**, *43*, 377–385. [[CrossRef](#)] [[PubMed](#)]
4. Jarvis, S.W.; Fraser, L.K.; Langton, T.; Hewitt, C.E.; Doran, T. Epidemiology of gender dysphoria and gender incongruence in children and young people attending primary care practices in England: Retrospective cohort study. *Arch. Dis. Child.* **2025**, *110*, 612–621. [[CrossRef](#)] [[PubMed](#)]
5. Troupi, M.; Tsousi, S.; Sergentanis, T.N.; Tsitsika, A.K. Gender Incongruence: An Overview of Current Status and Perspectives. In *GeNeDIS 2024*; Vlamos, P., Ed.; Advances in Experimental Medicine and Biology; Springer: Cham, Switzerland, 2026; Volume 1489. [[CrossRef](#)] [[PubMed](#)]
6. Guerin, E. What Are the Benefits of Educating Nurses on Transgender Health? *Transgend. Health* **2021**, *6*, 185–187. [[CrossRef](#)] [[PubMed](#)]

7. Băluță, I.; Tufiş, C. *Barometrul Violentei de Gen 2022: Violenta împotriva Femeilor în România*; Presa Universitară Clujeană: Cluj-Napoca, Romania, 2022.
8. David, D. *Psihologia Poporului Român. Profilul Psihologic al Românilor într-o Monografie Cognitiv-Experimentală*; Polirom: Iaşi, Romania, 2015.
9. Ellemers, N. Gender stereotypes. *Annu. Rev. Psychol.* **2018**, *69*, 275–298. [[CrossRef](#)] [[PubMed](#)]
10. Haines, E.L.; Deaux, K.; Lofaro, N. The times they are a-changing. . . or are they not? A comparison of gender stereotypes, 1983–2014. *Psychol. Women Q.* **2016**, *40*, 353–363. [[CrossRef](#)]
11. Kite, M.E.; Deaux, K.; Haines, E.L. Gender stereotypes. In *Psychology of Women: A Handbook of Issues and Theories*; Praeger: Westport, CT, USA, 2008.
12. Ramos, M.D.B.; Riera, J.R.M.; González, G.M. Actitudes de género y estereotipos en enfermería, [Gender attitudes and stereotypes in nursing]. *Cult. Cuid.* **2010**, *14*, 39–48. [[CrossRef](#)]
13. Parks-Stamm, E.J.; Leuthold, C.; Schuster, C.; Day-Murray, K.; Martiny, S.E. Playing the part: Children’s willingness and embarrassment to play gender stereotype-violating roles. *Br. J. Dev. Psychol.* **2026**, *44*, 417–436. [[CrossRef](#)] [[PubMed](#)]
14. Cuşnir, L. Percepțiile tinerilor privind calitățile individuale și rolurile de gen. *Rev. Filos. Sociol. Științe Polit.* **2019**, *181*, 3.
15. Kirchmeyer, C.; Bullin, C. Gender roles in a traditionally female occupation: A study of nurses. *J. Vocat. Behav.* **1997**, *50*, 78–95. [[CrossRef](#)]
16. Adams, K.A.; Nagoshi, C.T.; Filip-Crawford, G.; Terrell, H.K.; Nagoshi, J.L. Components of gender-nonconformity prejudice. *Int. J. Transgenderism* **2016**, *17*, 185–198. [[CrossRef](#)]
17. Asante, A.O.; Korsah, K.A.; Amoako, C. Does the gender of nurses matter to patients? *SAGE Open Med.* **2023**, *11*, 20503121231182514. [[CrossRef](#)] [[PubMed](#)]
18. Winkel, A.F.; Telzak, B.; Shaw, J.; Hollond, C.; Magro, J.; Nicholson, J.; Quinn, G. The role of gender in careers in medicine. *J. Gen. Intern. Med.* **2021**, *36*, 2392–2399. [[CrossRef](#)] [[PubMed](#)]
19. Prosen, M. Nursing students’ perception of gender-defined roles in nursing. *BMC Nurs.* **2022**, *21*, 104. [[CrossRef](#)] [[PubMed](#)]
20. Lyu, X.; Akkadechanunt, T.; Soivong, P.; Juntasopeepun, P.; Chontawan, R. A qualitative systematic review on the lived experience of men in nursing. *Nurs. Open* **2022**, *9*, 2263–2276. [[CrossRef](#)] [[PubMed](#)]
21. Bayuo, J.; Wong, K.C.A.; Abu-Odah, H.; Wong, F.K.Y. ‘Becoming and overcoming’: A qualitative meta-synthesis of the experiences of men in nursing academia. *J. Prof. Nurs.* **2022**, *43*, 83–106. [[CrossRef](#)] [[PubMed](#)]
22. Pololi, L.H.; Civian, J.T.; Brennan, R.T.; Dottolo, A.L.; Krupat, E. Experiencing the culture of academic medicine: Gender matters. *J. Gen. Intern. Med.* **2013**, *28*, 201–207. [[PubMed](#)]
23. Carr, P.L.; Raj, A.; Kaplan, S.E.; Terrin, N.; Breeze, J.L.; Freund, K.M. Gender differences in academic medicine. *Acad. Med.* **2018**, *93*, 1694–1699. [[CrossRef](#)] [[PubMed](#)]
24. Heffron, A.S.; Braun, K.M.; Allen-Savietta, C.; Filut, A.; Hanewall, C.; Huttenlocher, A.; Handelsman, J.; Carnes, M. Gender can influence student experiences in MD-PhD training. *J. Women’s Health* **2021**, *30*, 90–102. [[CrossRef](#)]
25. Isaac, C.; Griffin, L. Women chairs in academic medicine: Engendering strategic intuition. *J. Health Organ. Manag.* **2015**, *29*, 498–514. [[CrossRef](#)] [[PubMed](#)]
26. Sanfey, H.A.; Saalwachter-Schulman, A.R.; Nyhof-Young, J.M.; Eidelson, B.; Mann, B.D. Influences on medical student career choice: Gender or generation? *Arch. Surg.* **2006**, *141*, 1086–1094. [[CrossRef](#)] [[PubMed](#)]
27. Dream, S.; Woolfolk, M.; Chen, H. Gender role incongruity in general surgery applicants. *Am. J. Surg.* **2022**, *224*, 900–902. [[CrossRef](#)] [[PubMed](#)]
28. Mead, M. *Sex and Temperament in Three Primitive Societies*; Routledge & Kegan Paul: London, UK, 1963.
29. Parsons, T. *The Social Structure of the Family*; Free Press: New York, NY, USA, 1959.
30. Young, M.; Wallace, J.; Polachek, A. Gender differences in perceived domestic task equity: A study of professionals. *J. Fam. Issues* **2013**, *36*, 1751–1781. [[CrossRef](#)]
31. Bailon, C. Gender roles and mental health. In *The Traditional Individual in Society: A Study on Traditional Gender Roles and Mental Health*; Skidmore College: Saratoga Springs, NY, USA, 2019.
32. McFarland, M.J.; Wagner, B.G. College education and depressive symptoms. *Soc. Sci. Med.* **2015**, *146*, 75–84. [[CrossRef](#)] [[PubMed](#)]
33. Villatoro, A.P.; Mays, V.M.; Ponce, N.A.; Aneshensel, C.S. Intersectionality and mental health care. *Soc. Ment. Health* **2018**, *8*, 1–24. [[PubMed](#)]
34. Zhang, W.; Chen, Q.; McCubbin, H.; McCubbin, L.; Foley, S. Predictors of mental and physical health: Individual and neighbourhood levels of education, social well-being and ethnicity. *Health Place* **2011**, *17*, 238–247. [[CrossRef](#)] [[PubMed](#)]
35. Ueno, K. Mental health differences between young adults with and without same-sex contact: A simultaneous examination of underlying mechanisms. *J. Health Soc. Behav.* **2010**, *51*, 391–407. [[CrossRef](#)] [[PubMed](#)]
36. Mack, D.R.; Barth, J.M.; Masters, S. Gender stereotypes and goal congruity for adolescents’ preferred career and highly gender-stereotyped occupations. *Br. J. Dev. Psychol.* **2026**, *44*, 485–501. [[CrossRef](#)] [[PubMed](#)]

37. Szydłowski, M. Gender recognition and the rights to health and health care: Applying the principle of self-determination to transgender people. *Int. J. Transgenderism* **2016**, *17*, 141–150. [CrossRef]
38. Cantemir, A.; Cantemir, I.; Costache, A.; Dobrin, I.; Dobrin, R.; Stefanescu, C.; Chirita, R. Medical and Social Assistance for the Transgender Community: Difficulties and Particularities in Psychiatric and Psychotherapeutic Assistance. *Rev. Cercet. si Interv. Soc.* **2021**, *74*, 149–163. [CrossRef]
39. Casad, B.; Timko, B.R. Gender stereotypes. In *The SAGE Encyclopedia of Psychology and Gender*; SAGE: Thousand Oaks, CA, USA, 2015.
40. Coleman, E.; Radix, A.E.; Bouman, W.P.; Brown, G.R.; de Vries, A.L.C.; Deutsch, M.B.; Ettner, R.; Fraser, L.; Goodman, M.; Green, J.; et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int. J. Transgender Health* **2022**, *23*, S1–S259. [CrossRef] [PubMed]
41. Sarwar, A. Nursing Care Plan for Gender Identity Disorder. *Made for Medical*. Available online: <https://www.madeformedical.com/nursing-care-plan-for-gender-identity-disorder/> (accessed on 9 March 2024).
42. Pavlica, K.; Kalitová, K.; Khangpiboon, K. The role of education in supporting the well-being of gender-diverse individuals. *J. Nurs. Soc. Sci. Relat. Health Illn.* **2025**, *27*, 31–40. [CrossRef]
43. Available online: <https://ease.org.uk/wp-content/uploads/2023/01/EASE-SAGER-Checklist-2022.pdf> (accessed on 14 November 2024).
44. O'Brien, B.C.; Harris, I.B.; Beckman, T.J.; Reed, D.A.; Cook, D.A. Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Acad. Med.* **2014**, *89*, 1245–1251. [CrossRef] [PubMed]
45. Tong, A.; Sainsbury, P.; Craig, J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *Int. J. Qual. Health Care* **2007**, *19*, 349–357. [CrossRef] [PubMed]
46. Boniol, M.; McIsaac, M.; Xu, L.; Wuliji, T.; Diallo, K.; Campbell, J. *Gender Equity in the Health Workforce*; WHO: Geneva, Switzerland, 2019.

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