Cheng, Ling-fang (2008) , ‘Gender and Medical Profession in Taiwan’, Frontiers of Gender Studies (F-GENS), Institute for Gender Studies, Tokyo: Ochanomizu University, March 2008.pp.152-157

Gender and Medical Profession in Taiwan

Lingfang Cheng, Ph.D.
Associate Professor & Director
Graduate Institute of Gender Institute
Kaohsiung Medical University, Taiwan

Three issues were my main concern at the time I started the research: first, the study of women in the medical, as well as scientific and engineering professions, is important to have some insight on gender relations in professional education and on the job; second, although the patriarchal system had put constraints on individuals, some individual women did try to modify and resist the patriarchal system with determination and action; thus what and how were various interactions carried out between the system and individuals? Thirdly, what can we as feminist scholars in gender studies learn from these cases?

This study explores gender relations in the professionalisation of doctors in Taiwan over a hundred year period from the beginning of Japanese colonial rule in 1895 to the end of the 20th century. Data for the research was mainly obtained by means of in-depth interviews with 78 doctors, 35 males, and 43 females in three-generation cohorts.

The material collected was surveyed at macro, messo and micro levels with reference to three analytical categories: gender, race/ethnicity and class. At the macro level, the role of the state in the professionalisation of the medical profession was examined in its historical context and the interplay of class, generation and ethnic factors with gender relations in this process was investigated. At the messo and micro-levels, the embodiment of the ‘masculinist norm’ in medical institutions and their culture was explored through the interactions of training institutions, gendered discourses and individual actors and their detrimental effect on the careers of women doctors was exposed.

The study demonstrates that gender discourses and a masculinist workplace culture have played a crucial role in constituting the medical profession in Taiwan as

‘male’ and that its organisational rules, recruitment policies and achievement criteria are not as gender-neutral as they appear. It shows also that where the role of the state in shaping gender relations in the medical profession is concerned, the Taiwanese experience is different from that of Europe or America. Both the ‘institutional exclusion’ model and ‘cultural inclusion’ model can explain the marginalisation of women in the hierarchy of the medical profession in Taiwan at different historical stages.

If we take the ‘institutional exclusion’ model and the ‘cultural inclusion’ model as the markers for understanding medical professionalisation in Taiwan, a trilogy of points is perhaps the best way to make a long story short.

- 1895-1945: Founding period under Japanese Colonial rule – Institutional exclusion model are dominant.
- 1945-2000: Developing period Institutional exclusion model and the model of cultural inclusion of masculinity have been mutually co-productive.
- 2000- present: ‘Gender mainstreaming’ had been promoted by the United Nations for a decade and it is eventually accepted as the government policy in Taiwan around 2003. As enhanced by the promulgation of the ‘Gender Equity Education Act’ in 2004, a sea change was started within healthcare organization and nursing and medical education.

Before any further discussion, it would be useful to have an overview of the population of women in the profession in various historical stages. Since the first woman doctor, Dr. A-xin Cai, returned from a Japanese women’s medical college in 1926 and up to the end of Japanese rule, an estimated 6.9% of doctors were women (Cheng 1998, Fu 2005). By 1968, women doctors were about 5.4% of all doctors, which included the migrant women doctors who came from China in 1949. By 1974, the percentage dropped to 4%, which was due to the over one thousand male doctors demobilized from the military. By1980, adding some women graduates from medical colleges, the percentage went up a little bit to 4.3%. Since then, the percentage has steadily increased from 6% at 1990, up to 12% at 2000. Women medical students had also increased from 12% at 1990 to 20% at 2000 (Cheng 1998, Huang 2002, Ministry of Education 1990 & 2000).

Part I: Establishing a male-only medical profession under Japanese Colonial Rule (1895-1949)

The establishment of the (bio)medical profession as a contrast to the traditional herbal profession in Taiwan was entirely imposed upon the people of the island by Japanese colonial rule. It was a male-only profession, as a result of the gender ideology and institutional exclusion of colonial rule. This made me wonder why it was possible to have women's medical colleges in Japan but not in colonial Taiwan.

According to Mara Patessio & Mariko Ogawa (2005), despite the patriarchal ideology deeply held by the government and people at the time, it was due to the struggle by ambitious women – such as 荻野吟子 (Ogino Ginko)，高橋端子，岡見京子，Ikezawa Kuno, （生澤久野）, and 吉岡彌生 (Yoshika Yayoi) – demanding the right for women to be educated in medicine, who opened the Tokyo Women's Medical School in Dec. 1900. The success in winning women's rights to obtain a medical education did not became part of government policy, and was especially ignored under the war government; thus the importance of women doctors to female patients received insufficient attention from the government all way through the war.

Now let us turn to colonial Taiwan. In the past, the traditional Chinese herbal medicine was passed down from fathers to sons or sons-in-law. Daughters were forbidden to learn the trade. Women received no formal education, except those from well off families who would provide daughters with some private teaching. This continued until the introduction of women's formal education by the colonial government. However, the purpose of female education was to cultivate good wives and virtuous mothers, so the content of female education was very different from that of males, and far behind in terms of academic level. So as a result women were not forbidden to attend medical school by any regulations but were excluded by the inaccessibility of academic qualifications as well as gender ideology.

Moreover, under the authoritarian colonial control, no liberal male intellectuals would support women's rights for medical education, and there was little possibility that women activists would appear. For intelligent young women in Taiwan, the only alternative for a medical education was to go to the 'motherland' to receive medical education in women's colleges. During this period, the institutional exclusion model was dominant and the gender ideology of the ruler and the ruled played an important role as well.

Part II From male only to women as minority (1945-2000)

The arrival of the Nationalist Government in 1945 from China brought gender

equal education and was the turning point for women's education in general and medical education in particular. During the period, the 'institutional exclusion' model and the model of 'cultural inclusion of masculinity' have been mutually co-productive and actively interplayed.

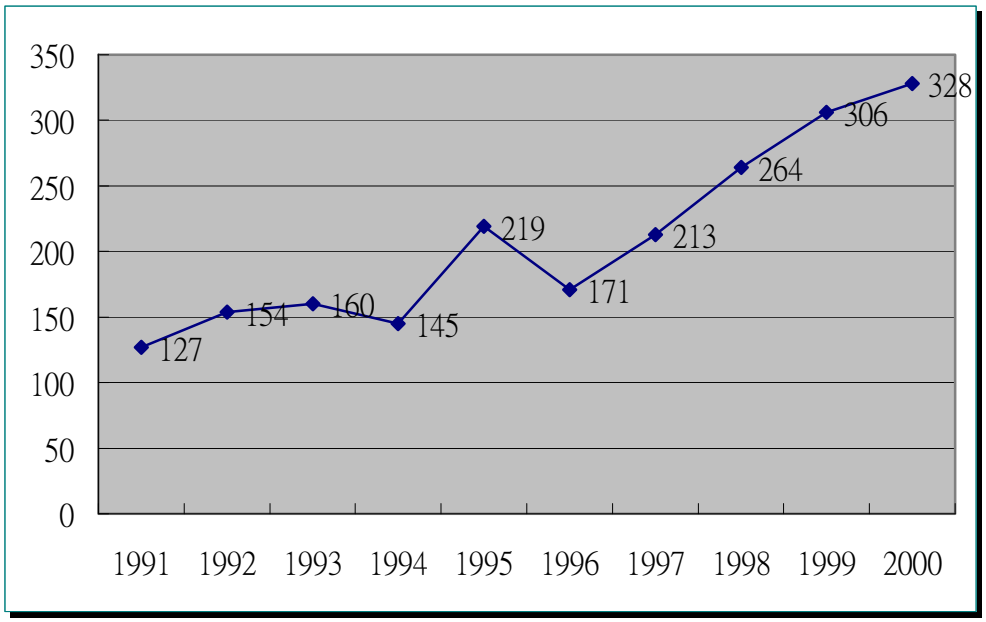
A. Medical Education

The number of women students in medical education steadily grew in the last 50 years. The following diagram comes from partial data but can demonstrate this tendency.

Graduates of all Medical Departments in Taiwan (1982-2000) by Sex

Source: The Ministry of Education (2002)

Year	Male%	Female%
1982	88.4	11.6
1983	91.5	8.5
1984	88.5	11.5
1985	90.6	9.4
1986	87.5	12.5
1987	88.4	11.6
1988	87.5	12.5
1989	88.4	11.6
1990	90	10
1991	86.9	13.1
1992	84.6	15.4
1993	82.7	17.3
1994	84.7	15.3
1995	78.2	21.8
1996	82.6	17.4
1997	77.6	22.4
1998	73.3	26.7
1999	70.7	29.3
2000	70.1	29.9



However, there is a surprising tendency for higher academic degrees. More women than men preferred to attend master and Ph.D. degree programs (see the following table). By the 1990's Women constituted 30% of master degree students. My explanation is for two significant reasons: first, most of the women master students came from middle-class families, so they have less financial burdens. Second, holding a master or Ph.D. degree at the time was an essential qualification for teaching posts. Teaching earned much less than clinical practice, so it was not an attractive option for men. Unlike women medical students, male students from less well off families were duty-bound to to make and save a lot of money in order to reduce family debts or to provide for their future family, after obtaining a degree and a license. Traditional gender roles and values influenced their career choices.

Holders of Master and Ph.D. Degrees in Medicine in Taiwan (1982-1994) by Sex

Source：The Ministry of Education（1996）

	Master			PhD		
	Male	Female	Female（%）	Male	Female	Female（%）
1982	0	0	0	0	0	0
1983	6	3	33.3	0	0	0
1984	5	6	54.5	3	0	0

1985	10	8	44.4	3	0	0
1986	12	3	20	1	1	50
1987	5	5	50	5	2	28.6
1988	11	4	26.7	3	1	25
1989	10	8	44.4	3	3	50
1990	12	6	33.3	4	2	33.3
1991	49	13	26.5	10	2	16.7
1992	56	25	30.9	9	6	40
1993	35	28	44.4	2	2	50
1994	23	13	36.1	5	2	28.6
Total	234	122	34.3	48	21	30.4

B. Choice of Specialties and Pyramid Selection

The gender-stereotyped images for women doctors at the time were ‘Dragon Ladies’, ‘female Dr. Frankensteins’. It was due to the lack of available feminist discourses. As to medical education, female students were trained to have less (negative) femininity and more (positive) masculinity, which was assumed to be associated with the medical professionalism. As to the gender bias in medical knowledge, it has persisted without any challenges even up until now. These are a few of the aspects relating to the ‘cultural inclusion of masculinity’.

Within the medical specialties, a hierarchical image was established which has lasted for almost fifty years. Specialties were divded into major specialties and minor fields. The former was the four most profitable specialties, which were surgery, ob-gyn, pediatrics, and internal medicine; and the remaining specialties belonged to the minor specialties.

Before 1980 more women chose a career in pharmacy (feminine) instead of medicine (masculine). Most popular imageof the practice of medicine would involve female pharmacists who would assist their doctor husband in runing a small clinic while the family lived in quarters above the clinic If women entered medical department at colleges and met their husband-to-be –, they would choose ob-gyn or pediatrics, and the husbands would choose surgery or internal medicine; this way, they could run a clinic covering all the medical needs of the community. This changed after the 1980s as more hospitals were established and medical techniques developed, and more women would choose less demanding specialties, such as, ophthalmology, dermatology, radiology, and rehabilitation.

During the residential training period, many residents choose to stay in the

medical centers for training. However, the recruitment structure was structured like a pyramid. Many talented women were excluded through this process. A famous cosmetic female surgeon Dr. Lin illustrated the ‘cultural inclusion of masculinity’ in the medical profession with her own story given in the interview. Dr Lin entered the surgery department at a famous medical center in 1958, as only the second woman to become a resident in that specialty at the hospital. Her father was a surgeon and her uncle was the director of a famous Christian Hospital. Unfortunately, not even these powerful connections could compensate for her status as an expectant mother:

> ‘The year I had to apply for CR was the year I became pregnant. My husband had just joined me for residency training in the same section: surgery. I was voted out. Evidently, the professors believed that to choose me would have jeopardized the livelihoods of my male colleagues and their families. Their line was that as a married woman I should be able to survive with the support of my husband. But then, dropping a mere woman is no big deal, is it? (sarcastic laughter). ... In the years leading up to that, my performance had been very good and my sex was never mentioned. But as soon as I got pregnant, others began to blame me for being a woman. ... I think the most difficult stage in a woman doctor's career is the residency and sub-specialty training. If only she can get through that, get a VS post and gain her independence, her sex need not be a problem.’

Two assumptions underlie the above case: (1) that the performance of a pregnant woman cannot possibly be up to standard; (2) that the man is the breadwinner, a concept dating right back to the concept of the ‘family wage’ promoted by the British trade union movement in late 19th and early 20th century.

Regarding the first of these, it is clear that what performance criteria that may exist for judging residents, these are the invention solely of the academically successful men in the department. This results in the automatic penalizing of maternity. Essentially, criteria are based on the concept of ‘commitment’ held by those working according to the male biological clock.

As for the question of the ‘family wage’, it is assumed that it is ‘natural’ for a man to be financially responsible for the family and that his wife should remain in her proper sphere at home; if she works outside the home, it will only be to bring in a secondary income. Thus when resources are scarce, a married woman should not compete with male colleagues since she would be supported by her husband. What the

male authorities fail to realize is that for women doctors, especially for those who choose surgery as a career, working is not only for financial consideration, but is a means of self-fulfillment and achievement. In terms of work commitment, these female doctors do not differ greatly from their male counterparts.

Reading these two seemingly contradictory but in fact complementary discourses, one can easily see their interrelated logic: the medical profession is seen as a male world, the family as a female world. Giving birth is a sign of a drift toward motherhood, which is as such incompatible with the medical profession.

C. Career Promotion

Since the pyramid selection system carries out structural exclusion in the career promotion within the medical center and, before 2000, the head of department were almost always men, social networking was very important for doctors' career promotions. Usually it was much easier for men to form a kind of bond of 'brotherhood' with their male bosses. Many male doctors would go to wine bars serviced by female hosts after a dinner party with colleagues, whereas their female counterparts would go home to look after their own families. The social networking for female doctors was limited to the networks of husbands or classmates.

Studying abroad was and still is an important route for obtaining more prestigious qualifications, thus single women and married mother are made to wait for opportunities. Dr. Liu as a single woman told me in the interview:

> 'Actually I just overheard somebody talking about it. None of the male residents seemed to be showing much interest, yet noone had even asked me! So one day I seized the opportunity to put in a request to my boss: "I'd like to go abroad for training, but no one ever offered me the opportunity." My boss replied: "You're an unmarried woman, so what's the point of you're going abroad?" I said: "Surely whether I'm married or not has nothing to do with my eligibility to apply for training abroad!" I then eagerly pursued it through various channels, and eventually I got the opportunity.'

A male doctors studying abroad usually takes his entire family with him. The wife quits her job and the children attend a local school for foreign (English) education. Male doctors can concentrate on their research or clinical training while receiving the wholehearted care of their devoted wives and enjoy family life. Whereas female doctors studying abroad, usually takes her children and leaves her husband

behind, due to a gendered division of labor: the mother looks after her children, the father earns money. As a result, it seems many women doctors carry a double burden while studying abroad.

The interview material informs me that it is the female doctors, rather than the males, who worry about the different stages of their careers. This indicates that most of the women's anxieties were attributable to conflict with the male norm but were addressed by the women as problems with the professional norm. The career track was measured against male standards, described the male career experience and was timed by the male biological clock. Remembering how confident some of these women were of their performance in school, it would not be hard to imagine how anxious they could become on taking a different career route from their male classmates. However, they were expected to be good mothers and virtuous wives, so had 'the second shift' to do after work, as Hochschild (1989) studied. Dr. Wu told me in the interview: "In the last ten years, I have had no progress in terms of academic achievement; I just keep up the minimum learning in the everyday, because I need to look after my family. Whereas my husband always worked in the study after dinner and published many papers in the journals.'

Part.III Feminist Movement and Gender Mainstreaming (2000-present)

The second-wave feminist movement in Taiwan was initiated in the mid-seventies by Annette Hsiu-lian Lu (the current vice-president of the State), and it was actively promoted in the 1980s as many NGOs were set up for promoting various women's rights. By the 1990s, women's NGOs, with active involvement from feminist scholars, were pushing for the revision of patriarchal laws. By 2000, many feminist activists and scholars were recruited into local and central government departments. These "femocrats" made Gender Mainstreaming the main policy at all the government levels. Gender Mainstreaming has been the UN policy since 1995. Taiwan, however,is not a member of the UN and its policy is not necessarily implemented in Taiwan. So these femocrats have played an important role, which must be acknowledged. Thus there is now an atmosphere of gender equality at work and in education.

Throughout the years, many younger women doctors were influenced by the feminist movements, yet these have had little or no impact on the patriarchal systems of the profession. Individual awareness is important, but without legal and institutional support, it is unable to flourish. As a result of the efforts of feminist movement, in 2002, the Gender Equality in Employment Law was promulgated and in 2004, the Gender Equity Education Act was promulgated; the latter act is probably the

only one of its kind in the world. The Act demands all levels of educational institutions in Taiwan to apply the principle of gender equity. This means that, including medical education and on-the-job training for doctors. In 2006, the ‘Sexual Assault Prevention Act’ was promulgated, and the ‘Domestic Violence and Sexual Assault Prevention Committee” was established under the Ministry of the Interior. Under pressure from several important laws regarding gender equality, the most conservative and patriarchal profession, medicine, is slowly reacting to the changes. So far it is not possible to evaluate the changes. However, let me give you two examples from my own personal and current experiences to show that the heavy snows of patriarchal institutions and masculinist culture are slowly melting after a long period of feminist struggle.

In the field of medical education, some feminists–including me and some gender-friendly medical professors–were invited by the Medical Educational Commission to write a textbook on ‘Clinical Instruction and Case Discussion for Gender Equity in Medicine’. It was published in November 2007 and will be used for all matters regarding residential in the country. The Medical Educational Commission has also initiated, in May 2007, a teachers’ training course for medical professors on gender equality and will continue to do so every year. The course structure at medical colleges would be gradually modified and will integrate more material or classes on gender equality.

In the field of health policy, the ‘2020 White Paper on Health’ initiated by the Health Department of the Ministry of Interior is in the process of completion. It is very noticeable that the framework and the main principles of gender mainstreaming have been incorporated into the ‘2020 White Paper on Health’, especially in regard to the attention to LGBT (Lesbian, Gay, Bisexual and Transgender) health needs. I am very proud of the involvement and hope the ‘2020 White Paper’ will be implemented step by step.

It is certain that many issues on the promotion of gender equity in health work and medical education will meet strong resistance from male-centered professionals. This means that feminist government officials, NGO activists and academic scholars should continue to come up with new strategies, provocative discourses, and sharp analyses to keep the old struggle fresh and relevant.

References and further readings

Cheng, Ling-fang .1998. "En/gendering Doctors: Gender Relations in the Medical Profession in Taiwan 1945-1995"Ph.D Thesis, University of Essex.

Crompton, Rosemary. 1990. 'Professions in the Current Context', *Work, Employment and Society***,** special issue: 147-66.

----------,1990. *Gendered Jobs & Social Change.* London: Unwin Hyman.

Davies, Celia. 1996. 'The sociology of professions and the profession of gender', *Sociology,* 30(4): 661-678.

Epstein, Cynthia Fuchs.1970. *Woman's Place: Options and Limits in Professional Careers.* Berkeley: University of California Press

Franzway, S., Court, D. and Connell, R.W. 1989. *Staking a Claim: Feminism, Bureaucracy and the State.* Cambridge: Polity Press.

Glucksmann, Miriam. 1990. *Women Assemble*. London: Routledge

Hochschild, Arlie, 1989. *The Second Shift.* N.Y.: Avon Books.

MacDonald, Keith M. 1995. *The Sociology of the Professions.* London: Sage

Mara Patessio & Mariko Ogawa, 2005. 'To Become a Women Doctor in Early Meiji Japan (1868-1890): Women's Struggles and Ambitions', *Historia Scientiarum,* Vol.15. No.2.

Rista, Elianne and Wegar, Katerina (eds.) 1993a. *Gender, Work and Medicine.* London: Sage.

----------, 1993b. 'Women physician: A new forces in medicine' in *Gender, Work and Medicine.* Eds. by Elianne Rista and Katerina Wegar London: Sage.

Weisman, C.S., Levine, D.M., Steinwachs, D.M., and Chase, G.A.1980. 'Male and female physician career patterns: specialty choices and graduate training' *J. Med. Educ*. 55:813-825

Witz, Anne. 1992. *Professions and Patriarchy,* London: Routledge.