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Private Practice and Gendered Power

Women Doctors in Hong Kong

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Women Doctors in Hong Kong

This paper examines gender-related issues in the medical profession in Hong Kong, based on a recent study on women doctors using in-depth interviews and a questionnaire survey. The study finds that female doctors in Hong Kong are paradoxically members of a highly regarded profession and, at the same time, members of an underprivileged social category: women. Female doctors interviewed construct a career and make sense of their existence in a cultural milieu that is based on a male-oriented social structure and a patriarchal medical institution. They are seen to have internalized a set of values which defines motherhood as something "natural" to women and which takes it as "normal" that women should give priority to their familial duties over developing a career which is considered a male endeavour. Yet, simultaneously female doctors are confident of their intellectual ability as members of the medical profession. In the face of this dilemma, like many women in salaried jobs, women doctors resort to "keeping a balance" between professional commitment and familial demands. Failing this, they often partly give up or temporarily give up their professional work, in order to fulfil familial responsibilities. In the process, they come to accept an existent asymmetrical power relationship heavily skewed towards the male. The consequences of this are two-fold. Structurally the asymmetrical gender power relations of the medical institution are reinforced, relegating women in the profession to a subordinate position as career-building becomes interrupted and toned down. Culturally long-established gender roles in which females should embrace only an existence in the "private" realm, both professional and familial, are substantiated.

Of Power, Private and Practice

One of the major building blocks of the medical institution is the power hierarchy based on an apprenticeship system. Such a system heavily values seniority which determines one's professional status as well as the aspiration of upward mobility. Seniority is understood not only in terms of the length of time one spends in the profession, but also in terms of the relative position in any dyadic relationship in the system. Thus, seniors, to their juniors, are individuals who simultaneously teach professional techniques, provide personal counsel and assistance in securing jobs and, more importantly, are administrative supervisors who control assessment and promotion. For juniors to function well in the profession, be accepted and be able to develop their career, submission to such power hierarchy is often required. This is especially true for women doctors as they are repeatedly reminded that they are not meant to be in the profession but they have been really lucky to be admitted as members of that profession. And, to smoothly develop a medical career, they adopt an attitude of "leaving it to the old boys" and choose a path that is least likely to incite conflict. In the training phase, while in medical school, female students allow male professors to "discriminate the boys by being nicer to the girls." In the intern phase, female doctors believe their male seniors are more protective of them *vis-à-vis* the boys, but at the same time they lose out to male interns who are given more opportunities to learn clinical skills. Junior women doctors avoid conflict by jokingly protesting against their treatment but will not directly confront their seniors. In the long term too, they will avoid "male" specialties, such as orthopaedics and other sub-specialties in surgery, and select those that are considered "female," such as obstetrics and gynaecology, paediatrics or internal medicine. One interviewee wanted to go into surgery because she "did not want to do women's work like obstetrics and gynaecology." But, she was assigned to do pathology. She resented it in the beginning but later justified it to herself that since

it was a 9 to 5 job, it would be good for her family life. Thus, when conflict of interest arises, the solution is often resorting to avoidance and rationalization. Rather than fighting for their rights and a personal say, women tend to retreat to what is considered their rightful place — the private realm. Through their everyday life, they put into practice the rules imposed on them as females and doctors and act out a career path that is considered "normal" for women medical practitioners.

In my interviews, women doctors realize early on in their career that the expectations of a female and expectations of a doctor are mutually exclusive. One former medical student recounted the story of how, in the university orientation camp, she was told by a senior student that medical school was not for women because the curriculum was too tough. She did indeed decide to change her major in her second year, but not because she could not cope with the study. She was gravely worried that she would not be able to get married after receiving a degree in medicine. To interviewees who did finish their medical training, family building was also high on their priority. One interviewee decided to take a few years off in order to look after her two young children. Another one decided to go into private practice so that she could control her work time to fit into her children's schooling schedule. All these decisions to relegate oneself to the private sphere are seen to be "normal" by the women involved. In this paper, the private realm includes two spheres: the first one is the conventional equivalence to the domestic space, the home. The second is the non-public medical service supply end — private practice. The concepts of power, private and practice are thus intertwined at the institutional and cultural levels. In the following, I shall limit the discussion to the cultural interpretations of gendered power relationships and their institutionalization in the medical profession.

Private is Bliss

According to conventional wisdom, the single most valued achievement a woman can hope for in life is to be *haang fook*,[1] or literally "lucky and happy." Women in Hong Kong have often been told that, compared to women in other Asian countries, they are very *haang fook*, because, to name just a few examples, they have the opportunity to be educated, the opportunity to work and the opportunity to climb up the social ladder. As it goes, women have even *more* opportunities than men. People in the street can easily cite examples of successful females in the public realm. The head of the civil service, Anson Chan, is the prime example; and then, there are the heads of the Department of Health, Education Department, the Treasury, the Independent Commission Against Corruption, and the Equal Opportunities Commission, not to mention heads of various private enterprises. We are told *nui keung yahn*, or "strong women," are seen in all walks of life. Women are also considered *haang fook* because if they do not want to work outside the home, they can always go home and be supported by their husband. They do not have to suffer the pressure that men endure as breadwinners. In other words, it is socially accepted that women work not for economic necessity but for fun, and they can always fall back on a safety net, which is their husband. They can do this, as the argument goes, because Hong Kong men are less chauvinistic. This is often said with a tinge of jealousy at best, because underlying is the assumption that without the men's permission, women would never have been able to achieve anything outside the home. At worst, there is a widespread mentality that women should return to where they belong — the home — instead of taking up men's positions in the public realm.

However, being *haang fook* is a bliss that is skewed. One may have a *haang fook gar ting*, "a happy family," or *haang fook yahn saang*, "happy life." But, one cannot be described as having a *haang fook see yip*, "happy career." Men are *haang fook* if their wife fulfils

her responsibilities of being a perfect wife and mother, so that *they* can develop their career with the ease of mind that the home is well taken care of. Women are *haang fook* if *their husband* is successful in his career, is good to them and their children and *the children* excel academically. Thus, culturally women's fate and happiness are intertwined with marital and familial bliss based on achievement of those whom women serve instead of women themselves. Achievement for women is thus altruist and is limited to the private sphere and never refers to their individual career or achievement in the public sphere. The rightful source of bliss for women is thus motherhood. Chodorow (1974) in her now classic article, "Family Structure and Feminine Personality," uses a psychoanalytic approach to examine the social construction of the mother role and its reproduction from generation to generation by internalization of these values in the personality structure. However, there is obviously an institutional aspect to the definition and reproduction of gender roles. In her study of women in socialist China, Robinson (1985) identifies the state as an important actor in recreating motherhood by implementing policies that reinforce patriarchal values and give mandate to the motherhood role. She puts it succinctly:

> Not every woman need be a biological mother for this situation to obtain.... Rather, motherhood is invoked when women as a group are charged with the responsibility of nurturing, caring for and educating the young, of maintaining domestic harmony, of being cook, cleaner, seamstress, nursemaid. While individual women may escape, with pity if they are biologically incapable of bearing children, with scorn if they choose not to fulfil the role, women as a distinct group are expected to conform and accede to motherhood. (1985:34)

In this light, motherhood is the set of roles and values based on the activity of mothering, while the latter is the real action that takes place in relation to fulfilling that role. So while not all women are mothers, nonetheless they are expected to be one some day. And, regardless of age, class, etc., all women are believed to

be born with motherhood qualities. The larger society embraces the concept, and the government has through its policies in areas notably including labour, welfare and education, endorsed the ideology.

Professional vs Cultural Mandate

Studies on women in the professions since the 1970s have pointed to the unresolveable conflict between the commitment required by the profession and the social expectations asked of the female sex. Coser and Rokoff (1982), for example, argue that women in occupations in general suffer from a double bind in which women are negatively sanctioned whether they show a commitment to their work or otherwise. If they show a commitment to their work, which is required by their profession, they are considered not fulfilling their familial responsibilities. If, however, women do not show a commitment to their practice, they are deemed unprofessional.

Because female familial responsibilities and professional commitment are seen to be mutually exclusive, women in the professions find themselves in a very difficult situation indeed. In their study of women in medicine in the United States, Bourne and Wikler (1982) argue that women are restricted in their professional advancement because sex and commitment are defined using familiar stereotypes of masculinity and of men's familial roles. Such definitions relegate women to a "discriminatory environment" in the medical profession and preclude them from being both feminine and competent.

The situation in Hong Kong today, in the late 1990s, is strikingly similar to that in the United States in the late 1970s. Women doctors in the study face a similar dilemma in which, as professionals, they are expected to be competent, committed to their job and respected for their professional skills. But, as women, they are expected to be submissive, committed to their family and respected for being able to raise successful children and support

their husband as he further his career. This is often justified by folk sayings such as *sheung fu gau tsi* and *naam chu oi nui chu noi* — "assist the husband and teach the children" and "men concentrate in the public sphere and women concentrate in the private."

In the United States study, the discriminatory environment, according to Bourne and Wikler (1982), consists of two components. The first is a subtle discrimination that exists in the profession as acts of commission and acts of omission. Acts of commission, such as sexist jokes and insults, have the consequence of reminding women that they are unwanted, while acts of omission exclude women from certain events, such as "conversation and... informal learning experiences." Both of these acts draw a boundary of division in the medical profession according to sex and is evident in this recent study in Hong Kong. Delia Ng recounted her experience as an intern in a government hospital:[2]

> We were sitting in the canteen. There were five or six male doctors, and I was the only female. Then they started talking about something I don't even want to repeat to you. I just wanted to grab a glass of water and throw it at them.

She did not throw the water of course, and I asked what happened the next time she saw the same people. She said, "Well, what can you do? It was all right afterwards, but I was really angry at the time."

The second component of discriminatory environment is the maleness of the profession and its institution. This form of discrimination is more subtle because it comes from the social structure itself. The first aspect of this maleness in the medical profession lies in the personal characteristics expected of the practitioner. Doctors are measured according to a set of characteristics that are "male." In the United States case, good doctors are those who exhibit male qualities whether in the way they look or in the way they behave — as upper-middle-class white males. The field of medicine is thus male-defined. Women entering the field are seen to be "incongruent" because they have female characteristics and qualities. Furthermore, women are seen to be a threat because

a male context finds female presence unpredictable and does not know how to deal with it. Several of my interviewees believed their male professors in medical school did not scold them but would not hesitate to scold the male students precisely because the professors would not know what to do if the female students began to cry.

The second aspect of maleness consists of "the organization of work in medicine, the sequence of a medical career, and key professional norms... predicated on the conventional male role in the family and on the male biological 'clock'" (Bourne and Wikler, 1982:113). Based on Hochschild's study (1975) of academia, this idea argues that the period of intense career-building and the period of building a family overlap. This simultaneous requirement from two time- and energy-consuming activities, when posed to the male doctors, is resolved most easily by having a wife — "every active professional needs a wife" (Hunt and Hunt, 1982). Obviously, women doctors being the childbearers are disadvantaged as they participate in an institution that is primarily oriented towards the male. The conflict between pressure of work and the urgency to bear children before one becomes too old causes a high level of anxiety that is felt only by women medical practitioners.

Like their counterparts in the United States, women doctors in Hong Kong try to manage the contradiction by avoiding work situations that are deemed "too demanding." Interestingly, "too demanding" is not defined to be intellectually difficult. None of the women doctors I interviewed believe themselves to lack the intellectual capacity for a difficult job. Instead, "too demanding" means requiring a lot of time and physical presence, particularly when it comes into conflict with familial responsibilities. Women doctors will avoid work that will take away time that they think should be spent on their husband and children. They therefore enter a self-selection cycle and end up in so-called "female" jobs — jobs that require less extra time, give less financial return, bestow less status and prestige — jobs which are avoided by male practitioners. In the process, they also avoid coming into direct

competition with male doctors. As many of them are married to male doctors, this also means they avoid competition with their husband. For female doctors who have graduated in the early 1980s and are now considered senior in the medical field, the choice is clear: you either avoid getting married or bearing children altogether in order to lessen familial responsibilities, or you have to find a way to attain so-called "flexibility" or "balance." Most women doctors interviewed went into part-time or private practice precisely for this reason.

Women doctors frequently told me that getting married and giving birth had to be taken into consideration in their career planning. One of the most important moves in the medical career was to be admitted to professional colleges of specialties, which was mostly by examination. Such examinations required both a written paper and a clinical examination, the latter of which often carried a pre-requisite of hospital attachment up to a month at the place where the examination was to be taken. For my interviewees, these had to be done outside of Hong Kong, mainly in the United Kingdom, as these were the only post-graduate qualifications recognized by the colonial government. Before the doctors were eligible to sit for these examinations, they also had to accumulate a specified period of time at a recognized government hospital. The timing of such activities which frequently lasted a few years, had thus to be planned carefully. While men normally took into consideration such factors as their own preparation for examination and approval of leave by their supervisors, women had to consider additionally the intervals caused by marriage and childbirth. Sandra Wong, an obstetrician-gynaecologist, related her experience of taking her qualification examinations:

> I finished the recognized period of training before I got married, and then I gave birth to my first child after I passed the written exam. A year later I spent one month at a hospital in London for the attachment, and then I took the clinical exam. It was after that that I had my second child. Yes of course that was all planned. How else can one do all these?

Judy Chan, also in the same specialty, never married. But, when I asked her about whether women had any special issues to consider in their career path, she practically recited the following:

> No getting married in the first year after graduation. No childbirth before the exams. That's understood.

The first year after graduation is internship year and is generally considered to be the most physically demanding year for a doctor. This is the year when fresh medical graduates undergo a year of "hard labour" in public hospitals and earn their eligibility to register as doctors. Being on the lowest rung of the power hierarchy of doctors, they often have to be on 24-hour calls for days consecutively, have no regular sleep but instead take naps of a couple of hours, spend the night in "call rooms" and are unable to go home. While considered difficult, it is not impossible for male doctors to get married during their internship year. But, it is generally believed to be impossible for female doctors in their internship year to get married because a major role of a married woman is to be with her husband and soon to be giving birth to offspring.

Gendered Subjectivities

It has been argued that socio-economic development, especially in the form of economic independence and opportunity of higher education for women, will lead to equal status for the sexes. In many societies, among them Hong Kong, this has not happened. Particularly among female medical professionals, as individuals they derive a high self-esteem from their social prestige and substantial financial rewards as medical professionals. But, as women as a social category, they experience a rather low self-esteem within the medical profession due to the institution's discriminatory environment, as well as cultural expectations of motherhood in the larger society. In this study, I am struck by the rather homogeneous response that the state of gender equality in Hong Kong is acceptable, regardless of the sex of the respondents. In

particular, respondents do not identify different treatment of the sexes in the training process and work environment as being sexist. Although female doctors show a high level of grievance towards their loss of opportunity to excel in their profession because familial responsibilities have taken up the bulk of their time and energy, nonetheless they see it as their personal problem instead of looking at it as an institutional issue. Typically, respondents are convinced that the system is fair because there are no blatant sexist policies preventing women from studying medicine or taking qualification examinations. At the same time, internalized motherhood values provide justification for women to readily give up partly or temporarily their profession for the sake of the family. Most frequently, women are left alone to strive to be perfect mothers in the isolation of the patricentric nuclear family. For women professionals who have high regard for themselves and are ready to excel in the motherhood career, they will bring the task on themselves, but ultimately they will find it unsatisfactory because they are still interested in a career in medicine. They do not foresee that the situation will improve for them as individuals. But, they seem to find in numbers a source of power. As one interviewee said, "in obstetrics and gynaecology (O & G), we women have a louder voice than the men." She was referring to the O & G specialty which had the highest number of female practitioners, as well as to the O & G College Council, the specialty's self-governing body, where half the membership was female.

The lack of horizontal organization across specialties and the long-established male-led professional hierarchy, coupled with patriarchal social values, have indeed created a discriminatory environment in which female doctors work. The lack of sensitivity on the part of both female and male doctors to the issue being a structural one largely reinforce the asymmetric gender power relations of the medical institution. Women doctors resort to taking time off from their career or to entering private practice so that there is more autonomy in terms of time management. In either of these choices, women doctors are seen to accept that they belong

to the private sphere, both in the sense of the domestic sphere, their home, and in the sense of non-public institutions.

Conclusion

Women doctors in Hong Kong are faced with two identities that are diametrically opposed: that of a highly regarded professional as medical practitioner, and, at the same time, that of a poorly regarded role as homemaker. They not only have to struggle to carry out the double burden of being a doctor in the public sphere and a mother in the private sphere, but also have to deal with the psychological contestations in themselves trying to reconcile vastly different expectations in those two roles. Female doctors frequently resort to going into private practice in order to achieve a "balance" in their public and domestic responsibilities. In so doing, structurally they reinforce the asymmetrical gender power relations of the medical institution, relegating themselves to a subordinate position in the profession. Culturally, they reinforce long-established gender roles in which women's place is defined in the "private" realm, both professional and familial. Even in sub-specialties where women's number is proportionately larger (than in other sub-specialties, not men), their collective identity is still restrained and their voices largely unheard.

Notes

1. All transliterations are based on Cantonese which is the lingua franca in Hong Kong and the language of interviews in this study.
2. All names of people and institutions are pseudonyms to ensure anonymity of interviewees and the individuals they refer to.

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Private Practice and Gendered Power

Women Doctors in Hong Kong

Abstract

This paper examines the dilemma faced by female doctors as members of a highly regarded profession and, at the same time, members of an underprivileged social category: women. It was part of a pioneer study of gender and the professions in Hong Kong, using in-depth interviews of female professionals and a questionnaire survey of both sexes from five professions. This paper presents preliminary findings on the medical profession. It reveals the paradoxical subjectivities of female doctors who, on the one hand, experience a high self-esteem based on their social status derived from financial rewards, social prestige and collective power as members of a highly autonomous and defensive profession. On the other hand, women doctors find themselves suffering from a low self-esteem as they struggle to reconcile a double burden constructed from a full-time professional job and the social expectations to perform according to the perfect motherhood norms. Female doctors resort to going into private practice in order to achieve a "balance" of their public and domestic responsibilities. In so doing, structurally they reinforce the asymmetrical gender power relations of the medical institution, relegating themselves to a subordinate position as they give up competitive career-building. Culturally they substantiate, both knowingly and unknowingly, long-established gender roles in which females should embrace only an existence in the "private" realm, both professional and familial. Only when they assume a collective identity, and in combination with their professional status, do they find a voice of their own.

私人執業與性別化權力

香港的女醫生

譚少薇

（中文摘要）

本文審視香港女醫生面對的困局：一方面作爲受社會高度尊重的專業人士，另一方面卻是社會上受壓抑的類別 — 女性。本文是「性別與專業在香港：工作政治和性別的社會建構」研究計劃其中一部份，該研究計劃對香港的五個專業進行探討，主要方法爲對女性專業人士的深入訪談及對男女專業人士的問卷調查。本文根據該研究搜集對醫學專業的資料，提供初步分析。作者發現女醫生一方面享受經濟回報、社會尊崇，和作爲高度自主的專業團體的成員，但同時又要應付全職專業工作以及社會上完美的母親的規範所引致的雙重負擔，形成社會地位高，但卻自尊低落的矛盾心態。女醫生爲了對「公」與「私」兩個範疇的責任作出「平衡」，選擇以私人執業爲解決方法。女醫生放棄了通過競爭去建立事業，從社會結構角度看，她們實際上是強化了醫學制度內的不對等性別權力關係，將自己貶黜於從屬的地位。從文化層面看，她們鞏固了沿習的性別角色，認同了無論是專業上或家庭中女性只應存在於「私」範疇。只有當她們有一個集體身份認同以及同時確認自己的專業地位，她們才能尋回自己的聲音。