‘Mother Russia’ at Work

Gender Divisions in the Medical Profession

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ABSTRACT One of the most significant changes in the medical professions in Europe is the trend towards feminization. Some of the patterns of gender inequality arising from the feminization of the European medical professions are clearly apparent within the Russian medical profession, which experienced feminization 70 years ago. Yet little is known about the processes by which these patterns of gender inequality emerged and were maintained. This article is based on interviews with female doctors in Voronezh, Russia in 1996. It explores the attitudes of these women to gender divisions within the medical profession. This is placed within the wider context of Soviet and post-Soviet employment and family policies directed at women. It is suggested that the material and ideological focus on women’s role in reproduction had direct implications for the choices women made in relation to paid labour.

KEY WORDS gender inequality ◆ medical profession ◆ occupational segregation ◆ Russia ◆ Soviet Union

INTRODUCTION

In the Soviet era, despite proclamations of equality, there were clear patterns of gender inequality in most areas of Russian life. While the theoretical justification behind women’s liberation in Russia lay in their full participation in paid labour, the workplace was nonetheless a prominent site of gender inequality. Despite the radical transformation of Russian society since the collapse of the Soviet Union in 1991, policies towards female employment retain much of the language and indeed content of the Soviet era (Bridger et al., 1996). The participation of Russian women in paid labour is characterized by their horizontal segregation into particular occupations or sectors, and by their vertical segregation

(London, Thousand Oaks and New Delhi), Vol. 8(2): 181–199
[1350-5068(200105)8:2;181–199;016883]

into occupations with lower ratings of skill and/or authority. While in many respects the patterns of employment replicate those in the west, there are significant differences in relation to the social context within which these patterns arose, in the types of work women do, and in the gender discourses which frame explanations for occupational segregation.

An examination of occupational segregation within the medical profession offers an insight into the processes underpinning gender inequality in paid labour in Soviet and post-Soviet Russia. The Russian medical profession differs most dramatically from those in the west in relation to its predominantly female labour force. Since the 1930s, around 70 percent of doctors in Russia have been women. Despite the predominance of women within medicine as a whole, there was, and continues to be, a clear gender hierarchy within the profession, with women underrepresented in the most prestigious specialities and in academia. Nevertheless, very little research has been carried out either in Russia or in the west to explore the social construction of the Russian medical labour force (Harden, 1998).

There has been considerable international discussion in recent years of the changing nature of the medical profession (Armstrong, 1990; Elston, 1991; Friedson, 1989; Hafferty and McKinlay, 1993). One change frequently noted is the international trend towards the feminization of the medical profession (Klein, 1993). For example, while in Britain only 29 percent of doctors are women, the majority of current medical students are female (Crompton and Harris, 1998).

However, it has been noted that women are not entering medicine on equal terms with men. Rather, a dual labour market is being created, with women concentrated in primary care and in low-paid areas of the profession (Riska, 1993). Therefore, the trend towards feminization can be associated with processes of gender inequality. This raises questions about the nature of the power of the medical profession. Indeed, feminization 'raises the possibility that power in medicine resides not so much within the legitimacy (and supposed sanctity) of the clinical (physician–patient) encounter but rather within the structure of gender relations and within the relationship of organised medicine to other organisational entities, including the state' (Hafferty and McKinlay, 1993: 215).

Despite the recognition that the trend towards feminization may have wider implications, there has been little interest in the Russian medical profession, which has long been a 'feminized' profession. Analysts of the medical profession in Soviet and post-Soviet Russia tend to separate 'gendered' questions from other areas. For example, Field does not mention gender in his discussion of the prestige of the medical profession in Russia (Field, 1993). When the position of women in the medical

profession is discussed it is often in somewhat vague terms, without being placed in the wider context of gender inequality in Soviet Russia (Ryan, 1989). Moreover, there has been very little empirical work to explore the attitudes and experiences of women within the Russian medical profession.

This article is based on findings from research carried out with female doctors in Russia. It both describes their experiences and places them in the context of wider state policies toward women, in order to further the understanding of the patterns of gender inequality in the 'feminized' Russian medical profession. The first section provides an outline of the methods used in this study and the difficulties faced in researching in Russia. Second, the article examines trends in Soviet and post-Soviet state policy towards women. This provides a context from which the attitudes and choices of women in medicine can be understood. Third, the process by which the medical profession was feminized and the explanations given by women in medicine for their choice of career are examined. Finally, the factors that influence women's career paths within medicine are explored in order to provide a better understanding of gender divisions within the medical profession.

RESEARCHING IN RUSSIA

The data upon which the conclusions for this article are drawn form part of research into gender segregation in the medical profession in Russia, carried out in the city of Voronezh in 1996. Interviews were conducted with 15 female doctors and the head of a medical institute. In addition, questionnaires were completed by 24 female doctors. The interviews and questionnaires used a topic guide exploring the women's choices to enter the medical profession; decisions made about their career within medicine; the role and status of the medical profession; the impact that the post-Soviet reforms have had on their lives; and their attitudes towards the position of women in Russia. While it was originally intended to interview 40 doctors, time constraints resulted in the use of questionnaires. As far as was possible, respondents were encouraged to answer the questions, which were mainly open ended, in some depth.

Though I had been to Russia and to Voronezh on previous occasions, there were many difficulties faced. The research was carried out for a PhD thesis and as such there were limits on the time-scale within which the research was to be conducted. As a result, it proved difficult to establish official links with a hospital from which to build a sample, or to broaden out the research to different areas of Russia. I had to rely on friends in Voronezh to establish contacts with doctors and then to use snowballing techniques of sampling.

Nevertheless, without previous contacts within the medical profession, it proved difficult to find doctors willing to be interviewed. In part this may have been because they had little time to spare and there was no material benefit to them by being interviewed. Indeed, I often felt guilty in taking up their time to discuss their overwork and lack of time. There may also have been a suspicion among some about the motives of a foreigner in interviewing them. There were occasions when the interviewees were clearly uncomfortable and refused to be recorded. Nevertheless, there were also occasions when my foreign status was clearly a source of interest and questions were often asked about the work of doctors in Britain.

Moreover, in Russia there is a general lack of familiarity with this type of research. Sociological studies in Soviet Russia have tended to be almost entirely quantitative, though this is now changing. While well-meaning friends were often keen to set up interviews with doctors they knew, I was then often unable to discuss the nature of the research, gain consent from the interviewee directly or discuss the location for the interview. All the interviews were carried out in doctors' places of work, with restrictions on the time available and on privacy.

There are also difficulties in writing up the results of research carried out in a period of transition. In one respect, the speed of change means that research may appear outdated very quickly. However, another difficulty is in the presentation of the data. While some parts of the interviews with doctors referred to their lives, career decisions and restrictions on their choices within the Soviet period, other aspects such as the financial difficulties faced today clearly reflected concerns rooted in the post-Soviet era. I have tried to clarify, in each instance, which period is being referred to.

GENDER INEQUALITY AND THE RUSSIAN MEDICAL PROFESSION

The forms and nature of gender divisions in the Russian medical profession can be understood on three different levels. First, it is argued that there were structural constraints on women's participation in paid labour, in particular through state legislation and women's responsibilities in childcare. However, the social construction of the medical profession must also be understood in relation to discourses on the 'woman question'. In particular, the stress on women's role in reproduction was, and continues to be, central in shaping women's choices in employment. Finally, gender divisions must be understood as being situated in specific contexts. Certain general observations about women's employment in Soviet and post-Soviet Russia as a whole can be made. Nevertheless, the

forms these gender divisions take are defined by the ways in which women negotiate their choices within particular occupations. As Giddens notes, while people's actions always presuppose some kind of structure, their actions recreate the structures (Giddens, 1984).

THE 'WOMAN QUESTION' IN THE SOVIET UNION

State policies directed towards women in the Soviet Union were characterized by their pro-natalist character (Khotkina, 1994). Biological reproduction was important in the Soviet system in terms of the state's concern over the reproduction of the nation.[1] While there is considerable debate as to the nature of the 'nation', questions of nationhood figured prominently in the history of the USSR. The Soviet Union was in essence an amalgamation of nations, yet it was also a single entity which symbolized a new economic form. From its earliest days, the isolation of the USSR from the capitalist world established the need to strengthen its nationhood both ideologically and materially.

Women were regarded as central in both respects. The general term 'motherland' (*rodina*) was frequently used, allowing members of each nation within the Soviet Union to invoke their own perception of what the motherland referred to. Moreover, since the basis for the USSR was its status as a new economic system, building the economy was, from its onset, regarded as a key aspect of development. It was the task of women to ensure that the population, and hence the labour force, was maintained at such a level that the Soviet Union could itself be maintained, both through internal development and protection from external intervention. Its future was seen to depend on continuous growth based primarily on the reproductive potential of women, who were called upon to have more children. The roots of this discourse varied throughout the course of the Soviet system. While in the 1930s the need to build a strong economy meant women were expected to reproduce more workers, in the postwar era, the tensions of the Cold War exacerbated this need for more labourers, but also saw a general population decline arising from the Second World War. By the late 1970s, the demographic impact of the war on the population of childbearing age was negligible, yet it remained a key feature in demographic discussions. Indeed, the pro-natalist discourse retained its political currency long after any demographic imbalance arising from the war disappeared (Urlanis, 1980). The war losses and women's role in restoring the population became an integral component of the discursive construction of the Soviet motherland. In Russia today, wider demographic concerns still refer to the long-term impact of the war (Presidential Commission for Questions of Women, the Family and Demography, 1995).

However, there were also contradictions for the state inherent in women's reproductive role. On the one hand, childbearing was essential to the continuance of the system, for without it there would have been no generational replacement. On the other hand, women were also regarded as essential contributors to the development of the economy through their direct involvement in production, particularly under conditions of severe labour shortage, which was a central feature of the Soviet system. Yet it was believed that women's capacity to participate in paid labour was limited, at least in terms of time taken out immediately before and after childbirth, while their capacity to reproduce was undermined by their involvement in work that was often dangerous to their health.

The state employed a dual strategy to resolve this contradiction. In the context of a growing demand for labour, measures had to be taken to ensure the participation of women in the labour force while at the same time minimizing the risk to childbearing that women's participation in production may have posed. With this in mind, attempts were made to regulate biological reproduction directly through abortion legislation and contraceptive availability and more indirectly through increasingly conservative family legislation. Second, attempts were made to control women's paid labour by simultaneously encouraging and restricting their participation.

Protective legislation was particularly significant in this respect (Ilic, 1995). Protective measures, such as restrictions on the type of work women were allowed to do, were intended to address the potential risks that women's labour force participation created. However, the regulation of women's labour in this way was not only for their 'protection', but also served the needs of the economy. This was most notable during Perestroika. It was no coincidence that the attempt to rationalize industry, bringing with it the threat of mass unemployment, was paired with a heightened concern about women's work in that sector. This was reflected in Gorbachev's call for women to be allowed to return to their 'purely womanly mission' in the home (Gorbachev, 1987: 117).

WOMEN IN POST-SOVIET RUSSIA

In Russia today, the state's concern for women is equally transparent. Giving women the 'choice' to work or stay at home is not realistic for most women, and the rhetoric of choice is, in reality, rooted in the desire to restructure the labour force rather than any concern for women's rights. This can be seen most clearly from family legislation. The draft family law of 1992, despite not being passed, contained a section 'On the Protection of the Working (or Student) Mother', which limited women's working week to 35 hours if she had children under 14 years. In addition, employers were

expected to pay twice the minimum wage to women for maternity leave, to transfer them to lighter work while pregnant and, if unable to do so, to release them on full pay (Khotkina, 1994). Within legislation, women's participation in paid labour is therefore integrally tied to their role in biological reproduction. This was illustrated by the Minister of Labour in 1993, when he said, 'why should we employ women when men are employed? It is better if men work and women take care of the children and do housework' (Kay, 1995).

What is perhaps most significant is the retention of the Soviet-style pronatalist discourse to justify the restrictions placed on female employment. At the 'Protecting the Health of Mothers and Children' assembly in 1994, one speaker said of current demographic trends that 'the situation can be described in one word – catastrophe' (Baiduzhy, 1994). The role of women in reproduction, as an essential component in the future of Russia, is clearly indicated by this journalist's comment. 'Depopulation is leading to the degeneration of the people. The country's leaders go on and on about some sort of rebirth. Degeneration instead of the promised rebirth – that is what the reforms have given us' (*Pravda*, 16 July 1994: 2). Gender relations in post-Soviet Russia therefore retain much of their Soviet character and women are still viewed first and foremost as mothers – of their children and of the Russian nation.

Therefore, in post-Soviet Russia, women's involvement in paid labour is regulated by the state through the protection of women as mothers. This regulation can best be understood at different times in Soviet and post-Soviet history as a response to demographic concerns and the impact of paid labour on women's capacity for reproduction, and as a mechanism by which the workforce was made more flexible. It is within this context that we can begin to explore gender divisions within the Russian medical profession. The structuring of medicine as 'women's work' and the hierarchy within the profession must be understood within the wider context of the Soviet and post-Soviet state's assessment of the 'woman question'.

WOMEN'S WORK: FEMINIZATION OF THE RUSSIAN MEDICAL PROFESSION

Throughout the Soviet period women constituted the majority of doctors and this has remained unchanged in Russia today. An examination of the processes involved in establishing and maintaining this pattern of segregation must be placed within the context of the social transformation of the medical profession in Soviet Russia. Second, it must be understood in relation to the wider factors which shape women's employment choices.

The development of the medical profession in the Soviet Union was

characterized by two processes – deprofessionalization and feminization. Deprofessionalization was a clear and direct state strategy carried out by the Bolsheviks in the years immediately following the revolution in 1917 to gain control over the medical profession (Field, 1957). The widening of the medical profession in the post-revolution period was one of the key features of deprofessionalization. This in turn created a demand for new labour (Ryan, 1989: 36). The medical profession underwent a transition from a predominantly male to a predominantly female occupation in the period between the two world wars. In 1917, 17 percent of doctors were women, yet by 1940 61 percent were women. From the 1950s the figure fluctuated at around 65–70 percent (Ryan, 1989: 38). The relatively rapid entrance of women into the medical profession, indeed the feminization of the medical profession, arose out of the need to fill gaps within the health care labour force, but why was it women and not men that filled such places? Why did women enter such a low-status, low-paid profession?

Women in Medicine: Choices and Constraints

Women's choices to enter medicine were shaped by a number of factors. First, the entrance of women into medicine related to the differential opportunities available to men and women in Soviet Russia. A career in medicine, a profession that was severely criticized by the Soviet state and that was more lowly paid than many other professions, was not regarded by men as the best option (Sigerist, 1937: 66).[2] Within higher education a hierarchy emerged between different institutes, with medical institutes placed at the lower end, reflecting the hierarchy within the economy (Fitzpatrick, 1979: 5).

Moreover, women's choices were far more restricted than men's. Employment policy in Soviet Russia played a key role in limiting the career choices for women. In Soviet Russia, female labour was essential to the operation of the economy given the shortage of labour and the intensive development strategy. Yet, at the same time, women were regarded as mothers or potential mothers and as such had to be protected and aided in their carrying out of this role (Heitlinger, 1979; Lapidus, 1978). Limitations were set on the use of female labour, including their exclusion from a list of occupations deemed to be harmful to reproduction (Ilic, 1995). For women this meant not only that their opportunities to move into other areas of work were far more restricted than men's, but also that they were primarily responsible for their family's needs in addition to carrying out a full-time job. The implications of this for their career paths are examined shortly.

All of the women interviewed entered the profession during the Soviet era and the following discussion is based on their reflections on their

choices made during that time. One gynaecologist expressed the perceived limitations on women's choice of occupation. For her, 'the majority of doctors in Russia are women because women have to work, and where else would they work but in medicine? What better options are there for them?' (gynaecologist, age 53). As medicine became feminized, it became seen as the best professional choice for women. One woman noted that 'for women, doctor is the most prestigious profession' (retired endocrinologist, age 74). What is important here is not that she argued that medicine was the most prestigious profession, but that for women, whose choices were far narrower than men's, it was.

Many chose medicine over other professions because other professions were regarded as harder to enter. For example, one doctor had considered entering the science faculty to study physics, but 'I thought it would be easier to enter medicine because there are more opportunities for women in the medical institute. . . . There are fewer opportunities for intelligent women than for men' (dentist, age 41). Compared to other non-professional occupations, medicine was also regarded as a good option. 'Probably, it is easier to work in medicine than in a factory. Women are keen to become doctors because the conditions and the work is better than a lot of factory work, even though the pay is less' (medical statistician, age 39).

However, it must also be recognized that while Soviet policies were directed at all women, the way in which they affected them and the way women negotiated this varied between different class and ethnic groups.[3] For women from professional family backgrounds medical work was regarded as one of the best options in maintaining their class status.[4] The importance of parental influence in relation to the decision to enter medicine was also apparent. Indeed, over half of the respondents said that they chose to become a doctor because of this. Even in some cases where doctors did not want their children to follow in their footsteps, the influence of family tradition was strong. One woman said,

> My parents are doctors, in fact five generations of my family are doctors. But my parents didn't want me to be a doctor because of the low pay. But I was brought up with it and it just seemed natural. (Child cardiologist, age 35)

The material factors which shaped and sometimes limited women's choices were (re)produced by a gender discourse rooted in essentialist notions about women's character and role as reproducers and their resulting suitability for certain forms of employment. The essentialist currents in the pro-natalist discourses were reflected in the responses of female doctors to the question, 'Why are the majority of doctors in Russia female?' Most doctors mentioned characteristics such as kindness and gentleness, all aspects of caring, as the key features of women that make

them most suitable for work as doctors. For example, 'women are naturally very giving and caring people, so they want to help the sick' (dentist, age 41). This was often compared to what were regarded as male characteristics or, more often, failings. 'Women love to protect the weak and be close to people. They are honourable and hard working. Among men there are fewer of such character' (*terapevt*,[5] age 52).

The characteristics attributed to women in the doctors' comments were clearly related to their reproductive role. This was made explicit on a number of occasions in the interviews when doctors expressed a connection between women's reproductive capacities and their propensity for medicine.

> Women are more suited to being doctors because they are more kind, responsive and attentive. They take illness very close to their heart and are very empathetic. This is because they are mothers and it is in their nature. (Paediatrician, age 52)

Women's ability to reproduce was not only seen to make women more gentle, but it was also suggested that it gave them an innate tie with nature, which men could never achieve, and which made them more capable of understanding biology. 'Medicine is a human profession and it is necessary to know about the organism. Women are closer to nature and so know more about this than men' (dermatologist, age 45).[6]

GENDER DIVISIONS OF LABOUR WITHIN THE MEDICAL PROFESSION

The medical profession in Soviet Russia was characterized by clear divisions by speciality and level of care.[7] Divisions within the health service were also based on the stage of care – primary, secondary or tertiary care. The work of *terapevty*, paediatricians and gynaecologists at the primary care level tended to consist of referrals of patients to specialists, with only limited treatment being carried out.[8] This was contrasted with the work of tertiary care specialists within hospitals who had more control over patient care and worked in a more complex area (Ryan, 1989).

These divisions were also gender divisions. Women were underrepresented in the most prestigious areas of medicine. Academicians occupied the most prestigious and influential positions within the medical profession and yet only 10 percent of the top researchers were women. No women were elected to the Academy of Medical Science in the 1986 elections and at that time they comprised only five out of 48 corresponding members (Schecter, 1992: 154). Similarly, tertiary care within hospitals was a predominantly male domain, with women only accounting for 40

percent of doctors working at this level. On the other hand, women were overrepresented in primary care work. A similar pattern emerges when different specialities are examined more closely. Primary care specialities such as paediatrics were overwhelmingly female: 93.3 percent of doctors working in this field were women. At the other end of the spectrum, tertiary care specialists were predominantly male. Less than 40 percent of surgeons and only 25 percent of neurosurgeons were women (Navarro, 1977: 78). I was unable to obtain a more recent gender breakdown according to medical speciality, but conversations with practitioners and academics indicate that little has changed since this period.

Gender divisions within medicine were also apparent in relation to women's career development. Relatively few doctors in Russia gained more formal qualifications after specializing.[9] A survey carried out in the region of Tula, found that only 30.6 percent of doctors had been awarded any of the graded qualifications: 10.2 percent were category II, 15.1 percent category I and 5.3 percent were a higher category. The proportion of doctors with such a postgraduate qualification varied between specialities. While 44.9 percent of surgeons had a category rating, only 21.2 percent of *terapevty* did (Manerova, 1993). This points to the fact that there may indeed be a difference between male and female doctors' opportunities to improve their qualifications.[10]

How is it possible to explain these gender divisions? The doctors interviewed often explained their choice of speciality and further career choices in relation to their family responsibilities. Indeed, the time spent on their family responsibilities deterred women from entering some specialities.

> There are some specialities which are complicated in terms of gaining qualifications, for example surgery. If women are not married then they can give a lot of time to their work, but if women have a family and they don't have the possibility to hire someone to help them in the home, they must spend a lot of time with children and as housewives. Therefore, women find work which will not be taxing in the physical and emotional sense. (*Terapevt*, age 33)

This doctor went on to explain that family responsibilities were the main reason why she chose to be a *terapevt*.

> Personally I work in a polyclinic and this work suits me. While at work I attend to the sick and the rest of the time I have time for work in the home. If I worked in a hospital I would have to go to work in the morning, for six to eight hours and then I could be called back to work on the phone if one of the patients got worse. I would have to go to the hospital and that would distract me from my work in the home. (*Terapevt*, age 33)

Another feature of hospital work which influenced women's choice of

speciality was night-shifts. In Medvedskii's survey, 36 percent of students mentioned this as a factor in their choice (Medvedskii, 1990). One gynaecologist in a women's clinic noted the influence of this factor in changing the sex ratio of gynaecologists in hospitals and in clinics.

> In our clinic all the gynaecologists are women, but in the hospitals many are men. This is because in the hospitals the work is heavier. In the hospitals there is a lot of night work because most births happen at night and also they are on call a lot, so it is physically demanding and better for men. (Gynaecologist, age 50)

This may also be another reason for the distinction made between work in hospitals and in clinics. While for men work in secondary or tertiary care hospital specialities offering night-shifts may have been the most desirable since this offered the opportunity for increased earnings, for women family responsibilities made night-shift work far less appealing and often impossible. While in industry women commonly worked night-shifts, women in medicine appear to reject such work, despite the clear advantages in terms of their career. This may also be a reflection of attempts made by female doctors to establish their status as professionals rather than as workers.

It was not only in relation to the choice of speciality that family responsibilities were regarded as being a decisive factor. It was also argued that women's family responsibilities limited their opportunities for career development, while men were freer to devote themselves more fully to developing a career.

> It is harder for women to improve their qualifications because they have less time to spend on improving their careers as their time is spent looking after children. They also have to care for their husband. It is easier for men when they have little to do in the family and everything is done for them. (Retired *terapevt*, age 71)

Moreover, raising their qualifications was described as being more difficult for women because this often entailed study trips away from home and, again, their family responsibilities made this very difficult.

> If women study on courses in other cities it creates family problems. They have to consider who will look after their children and their home. They certainly cannot rely on their husbands to do this. (Paediatrician, age 39)

The description by women of the impact of their family responsibilities on the choice and development of their careers, must also be understood in relation to the gender discourse on women's work. As with the horizontal segregation of women in medicine, gender discourses also framed the explanations of the divisions of labour within medicine. There were

clear distinctions made between what is regarded as 'male' and 'female' specialities (Schecter, 1992: 171). The most frequently mentioned sex-typed speciality was paediatrics. The reasons given for this centred on women's reproductive functions and the greater understanding of children this provided her with. 'Because women give birth to children they have a special bond with them that means they can treat them much better' (paediatrician, age 57). Moreover, this 'special bond' seemed to refer to all women. One paediatrician noted this in saying,

> Women are suited to being paediatricians most of all because they are mothers and so are more closely tied to children. As mothers or potential mothers all women want to help children. (Paediatrician, age 52)

Women's essential nature was also the reason given by those who said that gynaecologists should be women. For example,

> Gynaecologists should be women because they understand women better than men and female patients feel more at ease with them. When I was at school there was a male gynaecologist to examine the girls and they all ran off. Women are self-conscious with men. (Paediatrician, age 52)

Finally, mention was frequently made of the work of *terapevty*. Again, women were deemed most suitable for this work because of their innate characteristics. '*Terapevty* should be women because this work incorporates female characteristics like kindness and compassion and patience' (sector doctor, age 25).

The type of work involved in the primary care specialities of paediatrician, gynaecologist and *terapevt* was regarded as the most suited to women's nature. In addition, certain specialities were deemed to be unsuitable for women, most notably surgery. It was argued by many that men were far more capable of working in this area than women. 'Surgeons have to be men because surgeons have to be very courageous and strong. They have to be like true men' (physical culture doctor, age 28). There are some exceptions however, in which it was felt that women could make good surgeons. Most notably, in line with the role of women in paediatrics, it was felt by many that women should be paediatric surgeons, 'because they understand children and can soothe them when they cry' (paediatrician, age 52). Even at the level of surgery, therefore, women's role seemed to be one of caring and nurturing. Only in one instance was women's physique cited as an advantage for surgery. 'There are some types of surgery which is [*sic*] more suitable for women, in particular micro surgery, because they are more delicate and so may be more accurate in such work' (medical statistician, age 39).

In relation to career development, questions were raised concerning women's lack of suitability as managers. It was pointed out by many

respondents that women are not as capable of organizing and leading as men. One doctor made this point, noting that 'leadership positions are not only specialists but also administrators and men are more decisive than women and so better in these positions' (ophthalmologist, age 45). Furthermore, it was argued by one doctor that women are less suited to working with the technology required in top research positions, so such posts should be given to men.

> There is also a perceived difference between men and women in terms of working with equipment. Men work much better with technology and understand it better than women, so higher posts that involve using new, modern equipment should be given to men. In general, if there is a man and a woman with the same education and experience then the preference should be given to the man. (Child cardiologist, age 35)

Moreover, it was argued that it was wrong for women to consider developing their careers. It was noted that the time spent working should be kept to a minimum and, therefore, no time should be spent on raising qualifications that could be better spent at home. This was contrasted with male careers, which were regarded as not only more important, but also more justified given the superior minds of men.

> Men have more distinguished, analytical minds and they are more ambitious. It is for men to rise up in his [*sic*] profession. I think it is enough for women to have a good job that they like. They should not spend all their time studying or working because they need to spend time having a family. If they are too busy working when can they do this? Also if they are too busy working, especially in some specialities, for example with x-rays, they might damage themselves and not be able to have children. Work should not be the most important thing in a woman's life, the family should be. (Medical statistician, age 39)

Therefore the discourses used in discussions of women's paid labour revolved heavily around the differences between men and women in relation to their role in reproduction. However, it was not only in relation to women's choices that their career paths were formed. There is also evidence of the channelling of women into particular specialities and away from others. For some, the choice of speciality was the direct result of being encouraged into areas of work by lecturers at the medical institute. Medvedskii noted the importance of teachers' influence in determining students' choices. He found that 21 percent of students cited teacher influence as the most important factor in their choice of speciality (Medvedskii, 1990).

This influence could be a positive and encouraging one, as was the case with one doctor who decided to enter gynaecology, in part because of the good relationship she had with her teacher in this area. As she said, 'I

really enjoyed the classes and she made it seem like a very interesting area of work. She was always keen to talk to us about her work' (gynaecologist, age 53). However, the influence could also be a negative and limiting one. One doctor who was initially unsure as to her speciality remembered a conversation with a lecturer when she suggested to him that she would like to be a surgeon.

> Even though this was only a suggestion, I was surprised at the forcefulness of his reply. 'Surgery is for men and you should not waste your time thinking about this.' This did put me off because at that age you are very impressionable, especially when it is with people who are teaching you. (Endocrinologist, age 35)

In addition, women's 'choices' in furthering their careers often lay outside their control. For many who wanted to raise their qualifications, permission was denied by their superiors. Indeed Manerova found that 41.7 percent stated failure to receive authorization as the reason for not raising qualifications, while only 27.2 percent mentioned family responsibilities (Manerova, 1993). One *terapevt* confronted this difficulty when she wanted to attend courses to prepare her for her exams.

> I was denied permission to attend courses because they said there was no-one to do my work while I was away. When I told them that my colleagues had agreed to distribute my work between them, I was still denied and I was told that I should try to improve myself as a wife and mother and worry more about my family and less about my work. (*Terapevt*, age 44)

CONCLUSION

The medical labour force in Soviet Russia was characterized by distinct patterns of gender segregation both horizontally and vertically. This continues to be the case in the post-Soviet period. For most of the women interviewed, their work as a doctor was a job, for some a vocation, but for very few was it a career. Despite the desire of girls from a professional background to remain in that occupational group, their ambition was relatively low. Again this highlights the differences between the medical profession in the west and in Russia. While frustration and anger were expressed at the poor working conditions and low pay, there was a degree of resignation and powerlessness in this respect.

Similarly, the women interviewed rarely considered their position within the medical hierarchy in relation to men. The patterns of occupational segregation within the medical profession were not regarded as a form of discrimination. Some believed that success depended very much on the individual. One typical response was that 'the word discrimination is too strong in general and everything depends on the

individual qualities of the doctor and their professional qualifications' (physical culture doctor, age 55). Even those who said it was easier for men to get into university, to get better jobs and to raise their qualifications, did not regard this as any form of discrimination against women, but rather as the natural outcome of male/female nature or as the result of women's family responsibilities.

> If there are two candidates and one is a woman with a family and the other is a man, they will choose the man. But this isn't discrimination. It's just the way things are. Men work harder than women because women have families. It is also easier for men to go on business trips or to conferences. This isn't discrimination, but simply the situation of women in our country. (Gynaecologist, age 50)

There are several interrelated factors which contribute to an understanding of this. First, women's responsibility for domestic labour and childcare limited the amount of time they could devote to their careers. Many women chose not to pursue careers in more demanding specialities given the extra pressures this would entail in their daily lives. Second, women's domestic and employment status was reflected in and perpetuated by the gender discourses on women's role in reproduction. This was manifested in the discussion by doctors of women's essential nature and the type of work they should and should not do. Women's reproductive role was central to the images of women as carers, nurturers, being gentle and patient, which influenced the doctor's choice of speciality. To a large extent, therefore, while women's work within medicine was regarded as secondary to that of men, for it was men who predominated in tertiary care work and who were in leadership positions, this was justified as being natural.

Moreover, there was no Soviet feminist movement proposing either ideas or action to counteract the essentialism inherent in official discourses. While equality was said to be achieved through women's labour force participation, women's role in reproduction consistently set them apart from men. Indeed, the Soviet discourses remain strong today, not in the sense of people believing them to be true, but in terms of the absence of another vocabulary for understanding systematic gender inequality and discrimination. Though this is now changing through the work of women's organizations and research centres, the legacy remains.

The extent to which gender divisions in the medical profession will change as Russian society itself undergoes change is yet to be seen. Employment and social policies do not seem to offer any reason to assume that any change for the better will occur. Indeed, the opposite may well be true (Bridger et al., 1996). The position of women in Russia has been undermined politically, economically and socially in the last 10 years (Dakin, 1995). At the same time the medical profession has been severely

criticized and is now one of the poorest paid occupational groups in the country, working in often impossible conditions. In the light of such trends it seems unlikely that more men will want to enter the profession, or that gender inequality within medicine will be challenged, enabling women to capitalize fully on their talents. This is a somewhat paradoxical situation, given the mounting health problems in post-Communist Russia.

NOTES

1. See Harden (forthcoming) for a theoretical analysis of gender inequality in Soviet Russia.
2. In pre-revolutionary Russia doctors were also relatively low paid as a professional group. While there were opportunities for increased earnings through private practice, the majority of doctors did not undertake this type of work. For a detailed account of the social position of doctors in tsarist Russia, see Frieden (1981).
3. See Pilkington (1992) for a discussion of difference and the use of 'women' as a category.
4. Field also noted that attempts to proletarianize medicine were never effective and doctors tended to come from professional families (Field, 1957: 65).
5. The work of the *terapevt* is similar to that of the GP in Britain.
6. It is interesting that despite the characterization of the physician in terms of their kindness and so on, the high level of public complaints raised against doctors would indicate that in reality the situation was very different. Doctors in Russia were frequently accused of being rude, thoughtless and generally unfriendly, in fact the antithesis of the 'ideal doctor' image presented in the interviews (Galayeva, 1987).
7. The degree of speciality in Soviet medicine can be accounted for in part, by the influence of Flexnarian or Scientific medicine. This was based on the belief that disease was caused by a dysfunction in the machinery of the body. It was a very mechanistic approach which easily led to speciality according to the function of different elements within the body machine (Navarro, 1977). This system also accounted in part for the hierarchy between specialities. Within a system based on Flexnarian medicine, regardless of the sex ratio, primary care specialities are always placed lower on the hierarchy (Paikin and Salina, 1978). From this perspective primary care is the least skilled since it is the least specialized and remains closer to the holistic approach.
8. Heitlinger makes this point in relation to Czechoslovakia.

> The specific structure and organisation of primary medical care is characterised by physical isolation from specialist work in polyclinics and hospitals, weak technological foundations, high patient loads, routinisation and monotony of work, dilemmas posed by 'dirty work', limited intellectual stimulation, excessive paperwork, low pay and low esteem from both the general public and colleagues in other specialities. (Heitlinger, 1991: 217)

9. Doctors can take exams which would enable them to pass through the hierarchy of II, I and higher categories. Pay is increased accordingly, though the difference in pay between the categories is quite small.
10. Pilkington notes that 83 percent of women workers in general did not raise their qualifications after marriage (Pilkington, 1992: 200).

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