LIFE BEFORE AND AFTER THE BAN: EXPERIENCES OF WOMEN PHYSICIANS WITH HEADSCARVES IN PUBLIC HEALTH SECTOR IN TURKEY

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submitted by **AYŞE SENA KÖŞGER** in partial fulfillment of the requirements for the degree of **Master of Science in Sociology, the Graduate School of Social Sciences of Middle East Technical University** by,

Prof. Dr. Yaşar KONDAKÇI
Dean
Graduate School of Social Sciences _____

Prof. Dr. Ayşe SAKTANBER
Head of Department
Department of Sociology _____

Prof. Dr. Ayşe SAKTANBER
Supervisor
Department of Sociology _____

Examining Committee Members:

Prof. Dr. Nilay KAYA (Head of the Examining Committee)
Ankara University
Department of Sociology _____

Prof. Dr. Ayşe SAKTANBER (Supervisor)
Middle East Technical University
Department of Sociology _____

Assoc. Prof. Dr. Fatma Umut BEŞPINAR
Middle East Technical University
Department of Sociology _____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last Name: Ayşe Sena KÖŞGER

Signature:

ABSTRACT

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KÖŞGER, Ayşe Sena
M.S., The Department of Sociology
Supervisor: Prof. Dr. Ayşe SAKTANBER

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The headscarf issue has been a substantial controversy for veiled women at work until the abolition of the headscarf ban in public institutions in 2013. Since then, veiled women have been working freely in public institutions. The abolition of the headscarf ban was introduced as a solution to veiled women's headscarf- and work-related problems. However, the current state of veiled women at work has not been inquired. This thesis analyzes veiled women physicians' workplace experiences in Turkey's public health sector and tries to identify lingering effects of the headscarf issue, if any.

Although the state of women physicians in the medical workplace and the relationship between veiled women and work have been studied widely, none of these studies focus on the state of veiled women physicians working in public health institutions after the abolition of the headscarf ban. To assess the effects of the headscarf issue on veiled women physicians in the medical workplace, semi-structured interviews were conducted with twenty-one veiled physicians who experienced the headscarf ban in their lives and are currently working in public health institutions in Ankara.

This study found that the prior headscarf ban affected veiled women physicians' medical specialty and workplace choices. Today, the ban's repercussions continue to some extent, and the headscarf shapes veiled physicians' workplace experiences negatively and positively. While some patients are pleased to be treated by veiled physicians, some medical professors are dissatisfied with having veiled physicians in their workplace. The medical hierarchy exacerbates the headscarf-based discrimination in the medical workplace.

Keywords: headscarf issue, headscarf ban, public health sector, veiled women physicians, gender discrimination at the professional workplace

ÖZ

YASAKTAN ÖNCEKİ VE SONRAKİ HAYAT: TÜRKİYE'DE KAMU SAĞLIK SEKTÖRÜNDEKİ BAŞÖRTÜLÜ KADIN HEKİMLERİN DENEYİMLERİ

KÖŞGER, Ayşe Sena
Yüksek Lisans, Sosyoloji Bölümü
Tez Yöneticisi: Prof. Dr. Ayşe SAKTANBER

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Başörtüsü meselesi, 2013 yılında kamu kurumlarında başörtüsü yasağının kaldırılmasına kadar, çalışan başörtülü kadınlar için önemli bir sorun olmuştur. Artık başörtülü kadınlar kamu kuruluşlarında özgürce çalışabilmektedirler. Başörtüsü yasağının kaldırılması, başörtülü kadınların başörtüsü ve işle ilgili sorunlarına çözüm olarak sunulmuştur. Ancak çalışan başörtülü kadınların mevcut durumu hiç sorgulanmamıştır. Bu tez, Türkiye'de kamu sağlık sektöründe çalışan başörtülü kadın hekimlerin işyeri deneyimlerini analiz etmekte ve varsa başörtüsü sorununun kalıcı etkilerini tespit etmeye çalışmaktadır.

Sağlık sektöründe kadın hekimlerin durumu ve başörtülü kadın ile iş ilişkisi geniş bir şekilde araştırılsa da, bu çalışmaların hiçbiri başörtüsü yasağının kaldırılmasının ardından kamu sağlık kurumlarında çalışan başörtülü kadın hekimlerin durumuna odaklanmamaktadır. Başörtüsü sorununun sağlık sektöründe başörtülü kadın hekimler üzerindeki etkilerini değerlendirmek amacıyla, hayatlarında başörtüsü yasağını tecrübe etmiş olan ve halihazırda Ankara'da kamu sağlık kurumlarında çalışan 21 başörtülü hekimle yarı yapılandırılmış görüşmeler yapılmıştır.

Bu çalışma, başörtüsü yasağının başörtülü kadın hekimlerin tıpta uzmanlık alanı seçimlerini ve işyeri tercihlerini etkilediğini ortaya koymuştur. Bugün yasağın yansımaları bir ölçüde devam etmekte ve başörtüsü, başörtülü hekimlerin işyeri deneyimlerini bazen olumsuz, bazı durumlarda olumlu yönde şekillendirmektedir. Bazı hastalar başörtülü hekimler tarafından tedavi edilmekten memnuniyet duyarken, bazı tıp profesörleri işyerinde başörtülü hekim bulunmasından memnun değildir. Tıbbi hiyerarşi, sağlık sektöründe başörtüsü temelli ayrımcılığı şiddetlendirmektedir.

Anahtar Kelimeler: başörtüsü meselesi, başörtüsü yasağı, kamu sağlık sektörü, başörtülü kadın hekimler, profesyonel işyerinde cinsiyet ayrımcılığı

To my family

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LIST OF ABBREVIATIONS

TUS	Examination for Specialty in Medicine
JDP	Justice and Development Party
YÖK	Council of Higher Education
EU	European Union
ECHR	European Court of Human Rights

CHAPTER 1

INTRODUCTION

1.1 Introduction

Since the 1980s, women with headscarves determine their education and work lives according to the headscarf ban. While some women found alternative ways abroad, some stayed and struggled for their rights, and others had to dismiss their education or work lives. The ban was lifted from universities in 2011 and public institutions in 2013. Since then, veiled women are free to participate in public education and employment.

Abolition of the headscarf ban was seen as the remedy of the long-lasting dispute between secularism and Islam and as a way of giving the rights of veiled women to education and employment back. However, to what extent and how the effects of the years-long headscarf ban in public institutions were eradicated is a question to be asked, particularly for women who have been affected from this ban.

It has been seven years since the abolition of the headscarf ban in public institutions in Turkey. However, the reconciliation between women with headscarves and the public sphere has not been that easy, considering the 30 years of the ban. An adaptation period both for women with headscarves and proponents of headscarf ban was required. Before and after the abolishment of the headscarf ban, the presence of veiled women in public employment was widely discussed in Turkish society. While some people elaborated on the issue from a secularist perspective, others questioned these women's professional competency. It has been usually argued that veiled women would act according to their religious beliefs and eventually hamper their professional performance.

On the other hand, the primary form of gender discrimination at work harasses women both veiled and non-veiled with similar socio-economic backgrounds. However, as Cindoğlu states, the headscarf is mostly the main reason behind the discrimination faced by professional women with headscarves (2011, p.5-6). When combined with the headscarf ban, these discriminations push veiled women to lower levels of socio-economic status in the society.

In this respect, this study aims to explore the situation of women physicians with headscarf after the abolition of headscarf ban in public institutions as well as their professional experiences prior to the abolition of headscarf ban in Turkey. The medical profession is both a highly prestigious and a difficult one to be attained. It also has a strict hierarchical nature. The hierarchy at medical institutions is based on seniority and medical knowledge. Therefore, hindering veiled physicians' access to medical information through actions such as not giving clinical cases to these physicians, ignoring them during training sessions, or rejecting their participation in surgical operations because of their attire constitute some significant examples of discrimination against veiled physicians on their way to obtain professional qualifications within the medical hierarchy.

1.2 Research Question and the Focus of the Thesis

The main research question that I try to explore in this thesis is “How the headscarf issue shaped the experiences of women physicians with headscarves in the public health sector after the abolition of the headscarf ban in Turkey?” For instance, Seçkinelgin (2006) argues that "The question of whether girls with Muslim headscarves should be allowed to attend public schools combines the issues of both recognition and provision of a public good, education in this particular case, with lifetime consequences." (p.751). In this connection, I tried to examine the possible impact of the headscarf and the previous headscarf ban on Muslim women with headscarves working in public institutions in Turkey, focusing on Muslim physicians with headscarves.

There are various reasons for choosing Muslim physicians with headscarves as the focus of this study. As I will discuss in the following sections, women have struggled to become physicians in Turkey since the late Ottoman period. The medical profession is highly qualified and requires years of education, hard work, dedication, and self-sacrifice. Physicians hold prestigious positions. They are always in demand. Therefore, one may expect that this profession needs strictly objective criteria and leaves less room for discrimination in the medical workplace for physicians. However, as elsewhere, gender discrimination puts women in medicine under challenging situations too. Considering this together with the previous headscarf ban shows that veiled women had to fight more to gain their rights to become physicians.

According to the Turkish medical education system, a physician candidate must do a compulsory medical service in a public health institution to start working as a physician. Therefore, during the headscarf ban, a veiled female physician encountered the headscarf ban either in education life, whether she went to a state university or not.

Thus, I also tried to seek answers to the following questions: How and in what ways does headscarf affect veiled physicians' work-life? How and to what extent the prior headscarf ban affects the work-life of female physicians? For instance, does it impact veiled physicians' decisions on selecting their occupation, their field of specialty, their workplace, and the like? What explicit and implicit barriers to progression do veiled physicians identify at different stages in their careers?

Gender in medicine has been studied by scholars from different disciplines, namely medicine, psychology, business, and sociology (Riska, 2001; Kilminster et al., 2007; Serrano, 2007; Roter & Hall, 1998; Roth et al., 2016; More, Fee & Parry, 2008; Kuhlmann & Annandale, 2012). The gender gap, medical residency, discrimination based on gender, social hierarchies based on gender, the social organization of medicine and its division of labor, physician-patient relationship, professional status and power, organizational justice, gendered substructure at healthcare workplace are among topics of discussion in the literature. They mainly argue that women mainly work in niches of the health care system or medical specialties characterized by relatively low earnings or prestige. The studies have gained importance and speed as the number of female doctors increase in the last couple of decades across the world.

There are several studies on female physicians in Turkish history (Atıcı&Erer, 2009; Ataman, 1999; Demirsoy et al., 2019; Öztürk-Türkmen, 2011; Konya, 2018). These studies analyze women's role in medicine throughout history, their participation in modern medicine, difficulties they faced while studying medicine, their struggle for becoming physicians, and the like. Women struggled to become physicians in Turkey since the late Ottoman period. However, the headscarf issue is not mentioned in the literature as a challenge that women physicians have.

On the other hand, women with headscarves and work have been studied diversely in Turkish literature. These studies mostly focused on veiled women in low-status jobs, clerical jobs in more conservative companies, or the public offices of Justice and Development Party (*Adalet ve Kalkınma Partisi*, JDP) municipalities (Cindoğlu, 2011; Sayan-Cengiz, 2016; Jelen, 2011; Karaca, 2013; Güveli, 2011). On the other hand, there is a significant literature on young, urban, educated women with headscarves and their Islamic identity in the public sphere (cf. Arat, 1998; 2016; Çınar, 2008; Göle, 1997, 2002; Özdalga, 1998; Saktanber, 1994, 2002a, 2006; Saktanber & Çorbacıoğlu, 2008; Seçkinelgin, 2006; White, 1999, 2002). However, none of these studies particularly focused on Muslim women with headscarves in public employment.

Taking the related literature into account, this thesis also aims to convey women with headscarves and work issues in Turkey into a new territory by questioning the headscarf's impact in public institutions and how the roles and meanings of headscarf change after the abolishment of the headscarf ban. I argue that studying female physicians with headscarves in Turkey will be a novel contribution to the literature for broadening the Muslim veiled women's employment literature and examining the intersection of gender and religion in a very prestigious profession.

This thesis distinguishes itself from previous research on the headscarf issue by questioning whether the headscarf ban was the only problem that restrains women with headscarves from entering public employment. Is there a radical change after the abolishment of the ban? How women with headscarves experience work life in public institutions, and how is their adoption process.

To analyze the inclusion of veiled Muslim physicians in public health employment, I adopted qualitative research methods. I conducted interviews with 21 women

physicians with headscarves who experienced the headscarf ban once and now work in public health institutions in Ankara. The interview process lasted approximately two months, from February to March 2020. I reached the participants first through my connections and then used a snowball sampling technique.

The majority of the physicians I interviewed are employed in public hospitals. Three of the physicians are working at Family Health Centres, and two participants are employed in public and private institutions as occupational physicians. Besides, to detect the impact of the February 28 process, I grouped the participants into two who spent up to 10 years in the profession and spent up to 30 years in the profession. The average number of years in the profession of participants is 14. The most senior physician has been in professional life for 32 years, and the youngest physician spent one and a half years in the medical profession.

Before moving to the headscarf ban in detail, the multiple meanings attributed to the headscarf should be elaborated. As Sayan-Cengiz (2016) argues, "women with headscarves are attributed a fixed and reified identity, marked as being the representatives of one lifestyle pitted against the other" (p.3). However, the headscarf contains numerous meanings for its wearer. Aktaş (2016, p.215) argues that the headscarf enables seclusion for some women, and for others, it facilitates joining the society. Headscarf functions as a marker of the wearer's identity, worldview, religious view, political stance, and the like. However, social scientists of several disciplines, depending on their socio-political stance, attribute numerous meanings to the headscarf and interpret the connotations, motivations, and reactions. Mainly, the connotations can be classified under three categories; a symbol of submission, resistance, and a way of consumerism.

In the first discourse, the headscarf is a symbol of the submission of women to men. It is a result of a patriarchal practice that oppresses women hence symbolizes backwardness. Here, women are victims and do not have the free will to choose what is right. According to the second discourse, on the other hand, with the impact of Islamist political activism and modern education, women with headscarves became political agents. The act of wearing the headscarf is an act of "free will, free choice, and resistance" (Sayan-Cengiz, 2016, p.50). Since modernization is associated with

westernization in the Turkish case, the headscarf connotes a threat to the secular modernization and Westernization project of the republic. The third discourse argues that since they were denied from the public sphere, women with headscarves used consumption patterns to become visible in the public sphere. They wanted to prove their presence in the public sphere through the capitalist system (Barbarosoğlu, 2015, p.35-36). Bilge (2010) evaluates the first two discourses as follows:

> Ultimately, the veil has become an over-determined cultural signifier predominantly disqualifying its wearer as a free-willed agentic subject, since one cannot voluntarily choose to wear such a symbol of female submission, while at the same time making her a dangerous agent, a civilizational threat to Western modernity (p.18).

The greater part of the studies on connotations of the headscarf overlooks one issue that is piety itself. Most of the women wear the headscarf just because Islam commands it. Nonetheless, some scholars shed light on this issue and regard the headscarf as a reflection of piety (Bilge, 2010; Cindoğlu, 2011; Şişman, 2011).

1.3 Modernization Project and the Image of Modern Turkish Woman

The headscarf has been a central point of debates revolving around modernization, secularism, the public sphere, and Islamism. On the other hand, women's participation in the professions emerged due to modernization and secularization projects. Women's education, entrance to the labor force, and public space occurrence brought the questions of women's appearance and attire. On the one hand, the republican regime integrated women into public space through education and employment reforms and unveiled the women while doing that. As Çınar (2008) puts it, "the Turkish nation was defined in terms of secularism, modernism, and Westernism by unveiling the female body" (p.903-4). Therefore, the headscarf and modernization came to mean the opposites.

In this connection, I briefly provide background information on the modernization process, the history of women's entry to medicine, and the history of the headscarf ban to understand better headscarf and women physicians' journey in the Turkish context.

Modernization reforms constitute the reference point in mapping out the women question in Turkey, which mainly culminated in the headscarf issue. The Turkish

modernization process dated back to the Tanzimat period (1839-76) and gained speed during nation-state building. Education, employment, political rights, and the daily lives of women have been reshaped during the modernization process. Today's nation-state is a result of the historical struggles over modernity, tradition, and religion since the second half of the Late Ottoman Period. Therefore, the women's question in Turkey tends to center around the nation-state-building process and republican reforms. At this point, a historical perspective is essential to understand the dynamics of women question in Turkey.

A series of legal reforms were made in the republican period for the sake of democracy and modernity. It is widely argued that the women in Turkey underwent an extraordinary experience due to the "total modification of the legal system under the reforms introduced by Atatürk" (Kağıtçıbaşı, 1986, p. 485). The adoption of the Turkish Civil Code in 1926, which is inspired by the Swiss Code substantially, changed the status of women in Turkey. The laws prohibited polygamy and gave wife and husband equal rights in family affairs such as divorce and child custody. Moreover, women's suffrage was given in 1930 in local elections and in 1934 at the national level.

In this connection, the relationship between women and nation-building should be elaborated. There are two main reasons behind women's being the main subjects of modernization: motherhood and visibility. Toprak (1990) defines Turkish women's emancipation as the instrument of transforming Turkish society from Islamic to Western. The main reason for this understanding is that "women play an important role in the family or transmitting the dominant cultural values to younger generations" (Toprak, 1990; p.43). Due to women's role as the primary caregiver for younger generations, cultural identity is protected through the mother-child relationship. Therefore, changing the lives of women will eventually change the whole society.

Women were encouraged to participate in public life but with modern attire. Education and employment are two key components of this public participation. Çınar (2008) argues that "women's place and role in society are the most significant indicators that Turkey is a modern and civilized country, a goal that can be achieved if and only if Turkey distances itself from Islam" (p. 901). Therefore, through abandoning its

Islamic Ottoman past, women became one of the most significant symbols of a new modern nation. As a result of the reforms weakening the religious identity in the public sphere, "the unveiled woman's body soon became the symbol of women's emancipation" (Keskin, 2002, p. 247).

As the primary determinant of social life and legal regulations, religion had the power to shape public and private relations. Therefore, religion's impact had to be demolished. To limit religion's impact on public affairs, reformers tried to confine it to the private sphere. Saktanber (2002b) explains this in detail as follows:

> In the formation of republican Turkish society, however, religion appeared as one of the most important problems to come to grips with. On the one hand, it posed a problem for the maintenance of state control over society, in the sense of sustaining the legal and the ethical legitimization; on the other hand, it constituted a problem in terms of building up a national identity to be shared by all sections of society, because of the extent to which religion formed the most powerful source of reference for the actualization of everyday life (p. 137-8).

After the establishment of the Republic, for instance, as it is pointed out by Aktaş (1989, p.143), in 1925, the hat law was introduced and required public servants and parliament members to wear a hat. This law gave civil servants the right to change the community's attire by controlling the attire and intervening when the law was violated. Therefore, this law substantially changed how people dress and, accordingly, paved the way for state authorities to ban women's veils in public institutions. Therefore, the hat law constituted the legal background of the headscarf ban in Turkey. However, there was no real legal base for the ban of the veil until the 1960s. Nevertheless, some municipalities had the right to ban the veil and arrest the women with a veil (Aktaş, 1989, pp.172-173).

The presence of veiled women in the public sphere challenged the legitimacy of the secular ruling class. In this regard, to show their support for new republican reforms, women, especially of the governing elite, abandoned the veil and adopted a modern dressing code (Saktanber, 2002; p.125).

Consequently, this complex set of dynamics of Turkey's political history took the headscarf from the piety context and politicized it. Therefore, "the Islamic headscarf was transformed from being a private question of piety to a public question of religious expression" (Saktanber & Çorbacıoğlu, 2008, p.518). Furthermore, the political

actions of the Justice and Development Party (*Adalet ve Kalkınma Partisi*, JDP) in subsequent years exacerbated this change of the meaning of the headscarf, which Saktanber and Çorbacıoğlu call "headscarf skepticism". Notably, the Turkish government initiated the European Union (EU) membership process and aimed to expand the limits of democracy. Before this date, Turkish citizens could apply to the European Convention of Human Rights (ECHR), as the government ratified the ECHR. As a result, human rights and freedom of religious expressions came to the fore in veiled women's fight for headscarf (Saktanber & Çorbacıoğlu, 2008, p.529).

The case of Leyla Şahin is important for being a successful representation of claiming freedom of the headscarf through the human rights perspective. She was a 5th-grade medical student at Istanbul University Çapa Medical Faculty in 1998 when she was denied continuing her education due to the headscarf ban (Benli, 2011, p.295). She went to Vienna to receive medical education after several attempts to demand her right to education. One attempt was applying to ECHR since Şahin's dismissal from university is a violation of her right to respect for private and family life, freedom of thought, freedom of expression, and prohibition of discrimination (Saktanber & Çorbacıoğlu, 2008, p.529). Six years later, in 2004, ECHR decided that there was no violation of rights since the Turkish state did nothing but protected its secular and democratic values (Seçkinelgin, 2006, p.762). The decision of the court caused numerous debates in academic and political circles.

1.4 Women's Entry into Medicine in Turkey

Education plays a crucial role in women's advancement. Among all republican reforms, education was seen as the most prominent and thus was used as the central mechanism in building a new, modern, and secular nation. As Kandiyoti (1991) states, "Portrayed as an unveiled participant in public affairs and appearing in all areas of education from engineering to law, women, as liberated from the backwardness, were constituted as the new face of nationalist ideology" (p. 432).

There is no doubt that women's entrance to the medical profession is directly related to the history of women's entrance to higher education and the labor force. Formerly,

women in healthcare were mainly midwives. As Macdonald (1995) states, the transition from agrarian to modern society has caused a shift from status knowledge to technical and scientific knowledge. In this connection, the modern institutionalization project of education and medicine excluded the women who did not receive modern medical education and introduced male healthcare professionals by accepting only male students. As a result, medical practice became male-dominated. That is to say, since women could not access medical education, their entrance to the medical profession was late.

The earliest information about women practicing physicians was found in the 15th century, in Cerrahiyetü'l Haniyye, the work of Şerefeddin Sabuncuoğlu, who was the head physician of the Amasya Darüşşifa (Sarı, 1998, p. 451-465). The work has miniatures in which women physicians were doing surgeries. Other records of the period proved that women were employed as physicians and mainly treated female patients in the Ottoman period. They served in several fields, treated patients, did surgeries and autopsies as well.

However, it should be noted that these earlier women physicians received traditional and Islamic medical knowledge mainly through a master-apprentice kind of relation. In the Ottoman period, modern and formal medical education was introduced as a part of the modernization process. Through educational reforms, the sources of medical knowledge altered from traditional and Islamic to western and secular. However, following these reforms, only male students were accepted for medical education. Again, women struggled to receive their educational rights in medicine.

Initially, women in medicine started to be trained as nurses and midwives. In the School of Medicine, which opened in 1826, midwifery was studied under surgery classes, and only male students were accepted. Sixteen years later, in 1842, women were started to be trained as midwives. Therefore, midwifery was the first vocational education for women in medicine. In 1845, after a 2-year midwifery education, 10 Muslim and 26 Christian women graduated and became the first registered female midwives (Çakır, 1994, p.299)

On the other hand, the formal education for nursing for women officially started only in 1908, when the School of Pharmacist, Dentist, Midwife and Nursing Women was

opened under the School of Medicine (Atıcı & Erer, 2009, p.108). Additionally, the ongoing wars increased the need for medical staff. Hence, women started to participate in treatments of war veterans actively. For instance, women's branch of the Red Crescent began to train Turkish nurses, and these nurses dedicatedly worked in hospitals during the Balkan Wars, the Dardanelles War, and World War 1 (Abadan-Unat, 1981, p.8; Atıcı & Erer, 2009, p.109).

Nevertheless, it took more time for women to become physicians. As stated earlier, although formal medical education was introduced as a part of modernization reforms, women students were excluded. Following the debates on the acceptance of women students to medical school, medical authorities declared that women could not become physicians (Genç-Kuzuca, 2007, p.41). Primary concerns were that these women physicians would not work after getting married or having children; studying with male students might be inappropriate; female physicians could not examine male patients and the like. Consequently, the need for women physicians was met through foreign female physicians who opened their clinics.

Twenty years later, medical authorities took a step back and stated that women could become physicians. Concerning this, three female students applied to the School of Medicine but were denied. Hereafter, the ambitious women who wanted to become physicians went abroad to receive medical education. For instance, Safiye Ali, the first Turkish female physician, went to Germany in 1916, Suat and Süeda Kâğıtçıoğlu went to Geneva in 1915 to receive medical education. Besides, Bedriye Veysi Bora got acceptance from Munich in 1918, Fatma Reşit Arif Atasagun from Boston Tufts University, and Hayrünnisa Ataullah from University of London School of Medicine in 1919 (Atıcı & Erer, 2009, p.109).

Meanwhile, the first medical school for girls, Department of Medicine Constantinople Women's College, was opened under American College for Girls, in İstanbul. In 1921, this school accepted Turkish students as well. However, this medical department was closed in 1924 due to the law on the unification of education. On the other hand, Dr. Besim Ömer Pasha, the chancellor of Darülfunun, strived hard to include women students in medical education. Due to his efforts, women students enrolled in medical school in 1922 and 10 female students started their medical education. In 1928, six

women students graduated and became physicians (Atıcı & Erer, 2009, p.109). It is important to note that three of these six women physicians were surgeons (Genç-Kuzuca, 2007, p.43). However, these reforms and initiatives are class-based and therefore applied only for the ruling elite, not for the society at large. For instance, Safiye Ali's father was aide-de-camp in the palace, Iffet Naim Onur's father was a pharmacist, and Fatma Müfide Kazım Küley's father was a physician (Atıcı & Erer, 2009, pp.109-110).

Kadıoğlu (1998) states that women physicians started to work for the government only in 1930. Before this date, women physicians were not allowed to work officially and hence served as self-employed physicians. Regarding this development, more and more women applied to receive medical education. It should also be added that according to Öncü (1981), the mass entrance of women to medicine is a post-World War 2 phenomenon (p.182). In the 1950s, only 10% of medical school graduates were women whereas this ratio increased to 25% in the 1970s.

A critical dimension of first female physicians is their role in the modernization process. Both male and female physicians of the modernization process, from the late Ottoman to early republican period, pursued a mission of not only treating patients but of actively contributing to the formation of a modern Turkish identity. Since physicians had mainly higher socio-economic backgrounds, they belonged to the intellectual and thus ruling elite. Therefore, they held the power to affect the society they lived in. Emphasizing the significance of science, rationality, and progress for modernization, which are also pillars of medicine, physicians tried to gain political power to lead the society on its way to modernity. In Terzioğlu's (1998) 's words, "… the medical students and doctors began to consider themselves as the legitimate pioneers of the modernization mission, due to their privileged access to the medical knowledge, as well as to Western ideas and resources" (p. 23).

According to Terzioğlu (1998), the Turkish woman physician is a republican phenomenon, as women gained their medical, educational rights in that period. Women physicians of the early republican period committed themselves to serve as models of contemporary, modern, and secular republican women. They aimed to guide society towards a secular, scientific, and modern way of life. Moreover, with their

notable presence in the formerly male-dominated profession and the public sphere, women physicians represented the Kemalist ideas. Still, it should be kept in mind that despite the commendation of Kemalist reformers, women physicians faced severe challenges during their medical education and practice.

Interestingly, it is worth mentioning here, the first female students who started to receive medical education in 1922 wore the veil, which covers the whole body, or headscarf (Aktaş, 1989, p.156). This shows that women with headscarves have been studying medicine since the beginning of medical education, so it should not be a surprise to see Muslim women physicians with headscarf in medical schools.

However, Islamic physicians' introduction to medicine was met with reactions in medical circles; because of the idea that the Islamic way of life would shake the ideological foundations of their secular professional perspective. Terzioğlu (1998) explains the entrance and augmentation of Islamic people in medicine:

> The rise of Islamic ideology and movement at the end of the 1980's contributed to the heterogenization within the health sector. The faculties of medicine which had excluded religious thinking since the early 19th century where the first medical school had been founded, became one of the main secular castles that should be conquered by the students who adopted Islamic thinking. The first groups of medical students who adopted Islamic view were faced with a strong negative reaction from the university administration and their teachers. The Islamic view of these students were usually identified through their veils in the case of women, and type of beard in the case of men. Some of the teachers and administrators who were against their ideology, tried to prevent their attendance at the faculty and the examinations that were held there (p. 67).

Within this context, the pioneering veiled women in medicine should be referred to. Hümeyra Ökten is the first veiled female physician in Turkey. Her dedicated professional life became an example for the next generations. As a hardworking student, Ökten was given the chance of selecting a faculty without any examinations, and she decided to become a physician, a profession in which she would do the utmost service to people. In order to finish her medical education without a problem, she decided not to wear a headscarf. However, in 1955, right after her graduation, she started to work as a physician with her headscarf in the tuberculosis dispensary. Although it was an unusual situation, people got used to it as they witness her success in her profession (Barbarosoğlu, 2009, p.90).

Gülsen Ataseven is also known as the pioneering veiled woman in medicine. Although she graduated at the top of the medical faculty, Ataseven was not allowed to give a speech during the graduation ceremony, which was a faculty tradition, and the second student of the faculty made the speech (Saktanber & Çorbacıoğlu. 2008, pp.522-523). Since she wanted to pursue a career in medicine to reach and help more people, she uncovered her headscarf during specialty. It should also be mentioned that when she met Hümeyra Ökten, the first veiled physician, during her medical education, she was impressed to see a successful physician with a headscarf, and this affected her decision to wear a headscarf (Barbarosoğlu, 2009, p.157).

Besides, it is crucial to mention that the standard features of the first university-graduate veiled women are that they are urban physicians or teachers; they studied without a headscarf and wore headscarf after their graduation; and were tried to stay out of sight to not to be noticed and suspended (Barbarosoğlu, 2015, p.29). That is to say, first veiled professionals sacrificed their headscarf to serve their country and did not prefer to fight for the headscarf since the republican regime was still determined to impose the modern attire.

1.5 The Chronology of Headscarf Ban in Turkey

The headscarf ban first became visible in 1964. Although she graduated at the top of the medical faculty, Gülsen Ataseven could not speak in the graduation ceremony, which was a faculty tradition. Instead, the second student of the faculty made the speech (Saktanber & Çorbacıoğlu, 2008, p.523).

The first expulsion from university education due to headscarf happened in 1968, in Ankara University, Faculty of Divinity (Aktaş, 1989, p.247). Since she refused to take off her headscarf, Hatice Babacan was expelled from the university. A group of students boycotted this decision for months, and boycotts ended as the faculty was closed temporarily. After two years of waiting for the court decision, Babacan retook the university entrance exam and studied in another faculty.

As more and more women became visible in the public sphere, women with headscarves have also started to enter areas that are regarded as specific to the elite

sections of society in the past, to study in universities and to take part in respectable professions the society with other women. However, as the number of veiled students increased, the bans gained speed, especially after the 1980s. Before that, Muslim people had debates on whether women should study or not.

Following the 1971 Turkish Military Memorandum, the pressure on women with headscarves increased. The headscarf was banned in public institutions step by step. In 1972, the Ministry of Education banned the headscarf in schools. In the same year, a veiled attorney was disbarred and could not practice her profession (Aktaş, 1990, p.30). Veiled students were expelled from universities. In 1978, the government banned the headscarf in public institutions. As a result, numerous women were forced to resign or expelled (Aktaş, 1990, p.48).

With the coup d'état in 1980, the headscarf became a symbol of reactionism. Right after the coup d'état, Prime Ministry issued a circular on state officials' clothing. Despite the regulations on hair, mustache, make-up, or clothing, sanctions mainly targeted officials with religious attire; women with headscarves and men with beards (Cindoğlu, 2011, p.33). This, in a sense, is an indication of the government's perspective on Islam.

The first legislation banning the headscarf was introduced in 1981. According to the law, teachers, students, and the administration in schools under the Ministry of Education were banned from wearing the headscarf. In 1982, the Council of Higher Education issued a circular on the attire forbidding the headscarf for the faculty members and students (Cindoğlu, 2011, p.34; cf. Arat, 1998; Özdalga, 1998). Following these bans, students organized wide protests and, in some cases, went on hunger strikes, mainly in the faculties of divinity, law, and language and history of Ankara University. In 1984, the Council of Higher Education introduced a new regulation that allows women to wear "turban", the new, modern, and urban way of veiling. Hence, authorities made a division between the headscarf, which is traditional, rural, and belonged to traditional women and the ban as a newly emerged symbol in secular public space (Saktanber & Çorbacıoğlu, 2008; Şişman, 2011).

These oppressive practices have increased and decreased in various periods. In 1988, a student amnesty was proclaimed and opened the way of the headscarf in universities.

However, this lasted short. One year later, in 1989, as per the application of Kenan Evren, the constitutional court repealed the law, and the ban came back (Sayan-Cengiz, 2016; p.163). In the 1989-1990 academic year, covered students were not allowed to enter university campuses. The ban was lifted again in 1990, and the decision to accept covered students was left to universities. Therefore, whereas some universities lifted the ban, some universities did not accept covered students.

As a result of the lifting ban and political changes during the coalition government led by the Welfare Party (*Refah Partisi*), Islam's visibility in the public sphere increased. As Sayan-Cengiz (2016) argues, as young, urban, educated women with headscarves became visible in urban public spaces, the meaning of the headscarf connoted as "a declaration of authentic identity challenging the difference" (p.7). Therefore, the headscarf subverted the binaries that put secularism to the "unmarked, privileged centre" (Çınar, 2008, p.902) by combining the exclusionary public sphere, the Westernized lifestyles, and the traditional Muslim women.

However, February 28, 1997 rigorously diminished this visibility. The headscarf became a matter of national security, and The National Security Council identified it "as one of the main indicators of the Islamic threat which called for the enforcement of the ban on the headscarf in all public places including classrooms, universities, and public offices" (Çınar, 2008, p.905).

After February 28, 1997, the ban was strictly implemented than before. Students were not allowed to take exams, were suspended from the university, received disciplinary punishments, were insulted, were expelled from school by the police force, and could not attend graduation ceremonies. The professors who accepted veiled students to lectures and exams were imposed penalties such as suspension or deduction from their salaries. While some women went abroad to receive a university education, some dropped out of the university, and some students and public servants took their headscarves off. Between 1998 and 2002, 5000 women were discharged due to their headscarves. More than 10000 women were forced to resign. At best, authorities changed veiled women's positions in the workplace (Cindoğlu, 2011, p.36).

On the other hand, even if women could graduate somehow, they could not work in public sector jobs. For instance, Aktaş (1990) stated that veiled physicians were not

allowed to take specialty examinations because their headscarves hinder their identification. Also, veiled physicians who studied without a headscarf or studied abroad with a headscarf could not perform their profession in public health organizations. They either applied to private hospitals or opened their clinics if they were lucky enough. In general, women who insisted on working with headscarves started to work in private-sector jobs, generally in professions not related to their education areas, and under low wage and heavy work conditions. Moreover, as Özipek (2008) states, since they knew that they were the only option for the veiled employee, the private sector organizations that employed veiled physicians, teachers, and the like, paid much lower wages than they paid to less qualified staff.

Subsequently, the Constitutional Court closed down the Welfare Party (*Refah Partisi*) in 1998. In the 1999 elections, Merve Kavakçı was elected as the first veiled parliament member through Virtue Party (*Fazilet Partisi*) She was protested during the oath-taking ceremony since she refused to take her headscarf off and was removed from the parliament (Göle, 2012, p. 95).

Especially in the period after February 28, medical students faced severe challenges. In addition to difficult education life, medical students were forced to fight against the medical faculty's repressive mindset all over the country. The medicine-specific incidents regarding the headscarf ban are as follows: on October 24, 1996, the Dean of Faculty of Medicine of Hacettepe University, Prof. Yavuz Renda banned using headscarves in all departments of the Faculty of Medicine with a circular. On March 18, 1998, the Istanbul University Faculty of Medicine (Çapa) banned the headscarf, and students were dismissed from classes. In 1998, the ban applied in Cerrahpaşa and Çapa Medical Faculties also started to be implemented in Trakya, İnönü, Erciyes, and Ankara Universities (Benli, 2011, p.56).

After the Justice and Development Party (*Adalet ve Kalkınma Partisi*, JDP) came to power in 2002, abolishing the headscarf ban was one of the prominent promises to its electorate. Contrary to the expectations, the party did not take any action in its first term. In 2008, the JDP passed an amendment to the constitution to give women the right to education with headscarves. However, the Constitutional Court canceled the amendment (Sayan-Cengiz, 2016, p.164).

Following a couple of government attempts, in early October 2010, the Turkish Council of Higher Education (YÖK) forbade university professors to expel students from their lectures because of their headscarves. With this decision, the decade-old headscarf ban was lifted. The official annulment of the headscarf ban in universities happened in 2011. Then in 2013, the government announced the "Democratization Package" (Al Jazeera, 2013). This package includes new dress regulation for public institutions that allows wearing the headscarf. With the promulgation of the headscarf ban's annulment in public institutions, women regained their right to work in the public sector. After that, more and more women entered the labor market.

Furthermore, the headscarf was allowed in secondary education and high school education in 2014. Today, women can work in the police force, the army, and the judiciary. This annulment of the headscarf ban normalized the headscarf issue, which was a hot topic of discussion since the early republican times. However, no study has been done on this issue so far.

In this thesis, I chose my research topic with an aim to highlight the new political conjuncture in which the headscarf debate is expected to be ended. I am strongly opposed to the objectification of veiled women as well as the stigmatization of headscarf as the identity mark of Muslim women in general, and in the workplace in particular. Therefore, from this perspective on, I tried to analyze the current situation of Muslim veiled physicians and reveal the working life of veiled women in public sector employment in such a prestigious profession which has always been a big challenge for women to attain either with headscarf or not. I also argue that veiled women are not a homogenous group. Therefore, a single narrative of a veiled physician cannot be generalized. Still, as I will try to show throughout this study, they have similar experiences due to wearing headscarves in the workplace that I will try to show the specific characters of these experiences and discuss their outcomes.

1.6 Chapter Overview

Chapter 1, the introduction chapter, serves as the basis for the thesis. The research question, the aim of the thesis, background information of Turkish political history

that cause the introduction of the headscarf ban for years are explained with a brief information on the related literature.

Chapter 2 critically examines the existing literature on the work experiences of Muslim women physicians with headscarves. Since there is no research done in Turkey on this issue, several literature pieces are discussed to shed light on the subject. First, the Turkish labor market characteristics are addressed with a specific focus on professional work as physicians are professionals. Then, veiled women and work literature is examined to place the veiled workforce in public employment. The second part of the chapter concentrates on women physicians. The literature on the gendered medical workplace, challenges female physicians face, the state, and women physicians' experiences in Turkey are presented. The chapter ends with veiled Muslim women's specific health sector experiences in various social and political contexts.

Chapter 3 explains the research design of the thesis. The research question, the primary motivation behind this study, research design, methods used in the thesis, medical workplace as the field of the thesis, personal and demographic information on participants, conceptual framework used for analyzing the data, and finally, the limitations of the thesis are elaborated one by one in this chapter.

Chapter 4 is the analysis chapter of the thesis in which the interview findings are interpreted through the literature presented in chapter 2. In this chapter, 6 key themes are determined to analyze the research findings. These key terms are: i) deciding to become a physician, ii) headscarf narratives and experiences during the headscarf ban, iii) psychological effects of the headscarf ban on student and professional lives of participants, iv) assessments upon the abolition of the headscarf ban, v) being a veiled physician in public health sector, and vi) being a female physician in public health sector.

Chapter 5, the concluding chapter of the thesis, provides a discussion of the research findings, answers the main research question, and points out the literature gap that this thesis aims to fill. It argues that since women physicians with headscarves made their residency and public health institution choices according to the previous headscarf ban, now they do not experience headscarf-related discrimination as much as it has been expected. In some cases, veiled physicians are exposed to positive discrimination

from the patients. However, the medical hierarchy harms veiled physicians: they are exposed to mobbing from some medical personnel higher than them in the medical hierarchy but do not face any headscarf-based discrimination of medical personnel equal or below in the medical hierarchy. Besides, when a patient argues with the physician for some reason, the discussion almost certainly involves the veiled physician's headscarf. Since the headscarf is an identity mark, patients attack it during the argument. On the other hand, patients have specific expectations from a veiled physician, such as showing more mercy or favoring them at others' expense, although it is unfair. In sum, veiled women physicians still face certain levels of discrimination based on the headscarf in the seventh year of freedom of the headscarf in public institutions. Besides, veiled women who experienced the headscarf ban in their lives are more sensitive about these discriminations than veiled physicians who have never witnessed a headscarf ban.

CHAPTER 2

LITERATURE REVIEW

In this chapter, I tried to set ground for analyzing the state of physicians with headscarves in public health institutions in Turkey. First, I briefly state the general state of women in Turkey's labor force. Secondly, I reveal the details of professional work as a distinct work type to which the physicians belong. After that, to detect the headscarf's impact on work relations, I point out the workplace experiences of women with headscarves in Turkey.

In the second part of the chapter, I focus on women physicians' specific position in the medical workplace. The literature on female physicians mainly discusses the medical workplace's gendered nature and related challenges female physicians face. Similarly, the literature on the state of women physicians in Turkey concentrates on gender discrimination. However, there is no study done in the field of physicians with headscarves in the medical workplace in Turkey. Therefore, to better grasp the experiences of physicians with headscarves in Turkey, addressing the literature on women with headscarves in the health sector in the world would be helpful.

2.1 Unraveling the Intermingled Link between Women, Professional Work, and the Headscarf

2.1.1 Female Labor Market Characteristics in Turkey

Starting with the statistical overview of Turkey's female labor market characteristics is essential to assess women's employment properly. The labor force participation rates are on the rise for both men and women in Turkey. However, the gender gap persists. In 2019, the male labor force participation rate was 78.2%, whereas women's labor

force participation rate is nearly half of men's, which is 38.7%. Furthermore, there is a considerable gap between the employment rates of men and women in Turkey. In 2019, 32.2% of women were employed, and the employment rate of men was 68.3%, which is more than twice women's employment rate (Turkstat, 2020).

Equally important, employment status is a significant indicator for illustrating the state of women in employment. In 2019, 67% of women in employment were regular or casual employees, whereas only 1.4% of women were employers. Moreover, 9% of women were own-account workers, and 23% worked as unpaid family workers (TurkStat, 2020).

In terms of economic activity, one can see that the services sector takes the lead, having 59% of women in employment in 2019. This rate is followed by the agricultural sector (25.1%) and industry (15.9%). In this period, only 55.4% of men were employed in the services sector. This shows that a great majority of women in employment prefer the services sector.

In general, the share of female employment has been declining in the agricultural sector and increasing in the services sector. This is due to rural-to-urban migrations and agricultural mechanization. Macdonald (1995) states that during the transition from an agrarian society to a modern capitalist market society, large-scale economic activities have started to occur outside the home and are mainly undertaken by men. Consequently, women have turned into domestic workers. Although women entered the workforce after a while, they held lower positions in low-prestigious jobs. Gönüllü and İçli (2001) found that in Turkey, in 2009, the number of women in the service sector surpassed the number of women in agriculture, for the first time.

In all economic activities, 21% of women work as services and salary workers. This ratio is followed by elementary occupation with 19% and professionals with 17% in 2019 (TurkStat, 2020). This statistic shows a massive discrepancy in required labor skills for women in the labor market.

Education is stated as the primary determinant of the labor force participation of women in Turkey. As the level of education increases, the possibility of participation of women in the labor market rises. There is little doubt that women with higher

qualification levels are more likely to be employed than women with lower levels of education. İlkkaracan (2012) explains this as follows:

> University education emerges as the most important determinant of labor force participation for women. A university graduate had nineteen times the odds of participating in the labor market as her counterpart with less than primary schooling; the odds were three times for a high-school graduate. Over time, there has been a substantial erosion of the pull of women with higher education into the labor market. In 1988, the odds for university-graduate women were as much as twenty-nine times, and for high-school graduates six times, compared with women who have less than primary-school education (p.20).

Educated women in Turkey mainly prefer service sector jobs that require expertise. Öztürk and Dedeoğlu (2010) argued that the urban and educated women in professional jobs -specifically banking, law, medicine, education, and engineering- represent more than one-third of the employees in these fields.

The labor force status by educational level statistics supports the arguments above. Overall, women with higher education have the highest employment ratio. In 2019, the employment rate of women with higher education was 58.3%, which showed a decline as the education level decreases. In the same period, only 14.5% of women without formal education were employed (TurkStat, 2020).

However, it should be noted that although the educational level has an impact on employment for both sexes, the employment rates of men are substantially higher than women's. In 2019, for instance, the employment rate of men with higher education was 77%. Moreover, the employment rate of women with higher education is lower than the employment rates of men with vocational high school, high school, and less than high school educations (TurkStat, 2020). This shows that education level affects the labor force participation of men and women differently.

Education is more of a requirement for women to be employed than for men. In this context, it can be said that the lower level of education of women is only one factor among others, causing low female labor participation rates. It is true that women's education reduces the wage gap and provides equal pay opportunity for men and women. Dildar (2015) stated that education could not fully explain female labor force participation. Similarly, according to Kasnakoğlu and Dayıoğlu (1997), discrimination

against women in the labor market persists and puts women in disadvantageous positions at work despite women's education level.

2.1.2 Women and Professional Work in Turkey

The level of education, prestige, and higher wages are examples of professional women's work characteristics. Although women from all sectors have work-related problems, professional women face a different kind of workplace discrimination. Since it is highly connected to the educational and professional lives of women physicians with headscarves, the literature of the sociology of professions is essential to be addressed in this thesis.

Formal education in an academic setting, together with specialized intellectual training, constitutes the core of professions. A professional has expertise deriving from formalized scientific training. "Professional knowledge is gained by dint of a lengthy and heroic individual effort. This effort results in knowledge as a 'possession' of the autonomous individual" (Davies, 1996, p.670).

Freidson (1974) states that education brings professionals the power to control the production and application of knowledge and skills. As a result, it provides legal authority to the professional that sustains the political position of privilege and the right to self-regulation. In other words, professionalism brings professional status and authority to an individual. In this connection, Bayrakçeken-Tüzel (2004) regards the exclusion of women from professions through hampering women's access to knowledge and the power it brings as a patriarchal control and power.

Bayrakçeken-Tüzel (2004) asserts that women have gained prestige and become advantageous in several ways as they have participated in professional work:

> First, women in professions have higher education in the abstract body of knowledge, on which their particular profession depends. They have skills and human capital. These qualifications place them on the highest levels of occupational hierarchy, which are highly remunerated compared to lower occupations. Second, due to specific characteristics of their work, they are not directly exposed to subordination and exclusion in the capitalist labor market. On the contrary, women who are the members of a privileged group such as professionals have a respectful position within the public domain that inserts them into power relations. Because of their class interests and

> cultural assets, professionals are distinguished even from the middle classes and considered to be close to the dominating classes. Third, due to their privileged positions and class locations their income is high, they can buy services for their domestic chores. Thus, their occupations do not become a second burden for them. Fourth, being professional gives women the opportunity to participate in the public realm, where they can influence the collective power (p.65-66).

Kardam and Toksöz (2004) point out that public sector employment has numerous advantages for women, such as providing social security and regular working hours, reconciling work-family obligations, and having lower-wage differences between men and women. As a result, public sector employment is mostly preferred by women in Turkey. Moreover, it provides a safe environment for women, unlike fragile private-sector jobs. As Eser (1997) states, the number of women working in the public sector has increased over the years.

The workforce characteristic of the public sector is different from the total workforce. For instance, most women with higher education in Turkey have been employed in the public sector as professionals. Nevertheless, despite their educational background, women in the public sector face challenges.

According to the labor statistics of the Ministry of Family, Labor and Social Services, General Directorate of Labor (2017), civil servants mainly cluster in two areas that are education, instruction, and science, and health and social services. Similarly, a great majority of female civil servants are employed in these economic activities. Education, instruction, and science is the main economic activity in which women are mostly employed. The women-to-men ratio is highest in the health and social services sector.

According to the abovementioned statistics, female civil servants in health and social services constitute 57.8% of the civil servants in this economic activity. Besides, health and social services are the only economic activity that the proportion of women surpasses men. That is to say, in the health sector, women consist of more than half of the employees. Almost all nurses and midwives are female. Moreover, Durgun-Şahin (2002) stated that female employees' rate is generally more than one-third in several professional groups, namely dentists, doctors, pharmacists, and veterinarians.

Formerly, the professions were strongly related to dominant social groups. Until quite recently, professionals had mainly upper-class and upper-middle-class backgrounds and professional family members. For instance, a significant number of physicians had

parents who were physicians (Volti, 2011, p.219). Although this class-based layout in professions has been dispersed to some extent, discrimination based on gender, religion, race, and ethnicity somehow persists in professional life.

As stated earlier, professional women's work characteristics differ from the overall female labor force in Turkey. Urban women are mainly employed in professional work. Still, the proportion of female professionals is lower than men. What is promising is that the gender difference in participation rates is lowest in professions than in other work types.

As women have entered into professional work, the questions regarding the obstacles women face, processes hampering women's advancement in professional work, and women's own experiences in the workplace have gained importance. Discriminatory practices against women in the workplace have become a subject of study for social scientists and economists. Although women hold higher positions in employment, they still encounter gender-based inequalities in work-life.

The literature on professional women in the labor market mainly focuses on the challenges they face. Family responsibilities, work-family balance, inequalities in promotion, career advancement, wage differences, and occupational segregation are the main problems of professional women (Urhan & Etiler, 2011; Kardam & Toksöz, 2004; Bayrakçeken-Tüzel, 2004; Crompton & Lyonette, 2011; Davies, 1996; Riska, 2014; Uhlenberg & Cooney, 1990; Coplan et al., 2012; Burke & Mattis, 2005).

This shows that the reflections of gender inequalities, regardless of education and qualification level, affect all women in employment. Gender-based discrimination in the workplace takes different forms in each sector, occupation, and job position. However, as Kardam and Toksöz (2004) reveal in their study, prevalent discriminatory practices can be observed during the hiring process, promotions, retirement, requesting permissions, and layoffs.

Gender exclusion occurs in two ways. First, organizational cultures such as informal relations surrounding work, leave women aside. As Fox and Hesse-Biber (1984) argue, "Women's exclusion from men's informal circles of communication and interaction has critical consequences for occupational success in the professions" (p.141). Social

networks in the workplace provide numerous advantages since professional knowledge floats around through these networks. Women are mostly excluded from these connections and therefore lack additional information flow, which might bring success in the workplace.

Secondly, gender bias distinguishes women through the invented division of skills in the workplace. Accordingly, men have technical and objective skills, whereas women have socially constructed skills. Their work experiences are determined according to their skills, which often push women out in the workplace.

Walby (1990) argues that patriarchal strategies in paid work try to subordinate women. The two main patriarchal strategies are exclusion and segregation. Throughout history, men have, one way or another, tried to limit and control the participation of women in employment. Similarly, Witz (1992) states that the "socio-political and institutional locations of male power in the public sphere" and "the extent to which the institutionalization of male power in this sphere" have a significant impact on understanding occupational professionalism (p.34). She uses the terms exclusion and demarcation while explaining professionalization strategies: the organizational responses of class-privileged men to labor market conditions. Her study suggests that

> Male dominance in the professional division of labor around the provision of medicine was crucially dependent upon the patriarchal structuring of those institutions and organisations that inhabit the sphere of civil society and of the institutional ensemble of the modern state (p.35).

In her study, Aycan (2004) analyses the individual and situational factors determining women's career advancement. High self-confidence, achievement orientation, determination, and career orientation are the individual factors contributing to women's career success. A home situation such as spousal support or help from family members or paid workers with childcare and housework positively affects women's career advancement. On the other hand, the work situation affects women's careers negatively. Women reported that they face difficulties in access to social and communication networks in male-dominated organizational cultures. Due to this lack of networks, women encounter discrimination in selection, performance appraisal, and promotion in the workplace.

2.1.3 Women, Headscarf and Work in Turkey

Women in the labor force cope up with numerous difficulties. Even though gender norm is the primary reason behind, cultural values, social class, and religious beliefs also impact the state of women in the labor market. Different social, political, economic, and cultural conditions shape women's experiences in the labor market. Although the factors hampering women's labor force participation in Turkey have been studied widely (Aycan, 2004; Pınar, Eser & Hardin, 2007; Kardam & Toksöz, 2004; Toksöz, 2011; Beşpınar, 2010; Buğra &Yakut-Çakar, 2010; Göksel, 2013; İlkkaracan, 2012; Özar & Günlük-Şenesen, 1998), the impact of the headscarf had often been neglected. In Turkey, the headscarf, standing at the intersection of religious, social, cultural, and political contexts, put covered women in controversial positions in the labor market.

Although there is a robust literature available concerning Muslim women with headscarves (cf. Arat, 1998; 2016; Çınar, 2008; Göle, 1997, 2002; Özdalga, 1998; Saktanber, 1994, 2002a, 2006; Saktanber & Çorbacıoğlu, 2008; Seçkinelgin, 2006; White, 1999, 2002), the impact of the previous headscarf ban on women in the labor force has been analyzed only by few (Cindoğlu, 2011; Sayan-Cengiz, 2016; Jelen, 2011; Karaca, 2013; Güveli, 2011). It should also be added that few studies specifically examined the impact of the headscarf ban on education (cf. Rankin & Aytaç, 2008). This subsection provides an overview of the studies on women with headscarves in the labor market and the headscarf ban's effects.

Güveli (2011) investigates how and to what extent the headscarf ban affected women's social and economic conditions in Turkey. Her study differs from previous research on veiled women by discussing political, historical, and philosophical frameworks. According to the research findings, women with headscarves have significantly lower education levels and, therefore, less likely to be employed than women without headscarves.

Pointing out the exclusionary aspect of the headscarf ban, Güveli (2011) asserts that the ban shapes class positions. "The ban slows down regional and upward social mobility by blocking women's educational attainment and labor market participation"

(p.174). Hence, the lower social classes could not reach higher status positions, keeping upper-class resources safe and benefiting the elites socially and economically.

The headscarf, in this connection, hampered social fluidity in Turkey during the industrialization period. She emphasizes that the ban "both directly and indirectly weakens the already fragile social position of women and breaks down women's protests against and resistance to these practices" (p.175). Overall, her study is crucial as it reveals the headscarf ban's role in determining class positions in Turkish society.

Equally important, Jelen (2011) examines the university-educated, upper-middle-class women's experiences and aspirations in universities and professional life. She questions these women's visibility as successful university students and professionals through their individual experiences. Jelen (2011) explains the situation of women with headscarves during the headscarf ban as follows:

> The vast majority of covered women in Turkey today either do not work outside the home, have difficulties finding a job which corresponds to their educational background and aspirations, or are employed in family-owned businesses (where the competition to obtain a position is less intense) (p.312).

She adds that for those employed in public institutions such as Justice and Development Party municipalities, the situation is similar. They are employed for clerical jobs with no upper mobility and lower wages than in the private sector. While pointing out the discrimination which educated women with headscarves confront in the job market, she asserts that:

> While many jobs have been made available in the private and public sector with the rise of the AKP currently in power, these positions are almost always low-paid clerical or service jobs. Very few hijabis can be found in management positions, especially in conservative companies or municipalities. The common critique to the discrimination argument, namely that it is easier to find a job as a hijabi than as an uncovered woman in AKP municipal offices today, deals with the quantity but not the quality of the aforementioned jobs. Many hijabi university graduates eventually quit their jobs after a few years because of the lack of job mobility and low pay that they experience on the Turkish job market today. (p.317)

She concludes that contrary to former literature, young university-educated women with headscarves aspire to get higher education and professional careers and claim equal gender relations both at work and home. Their emerging visibility in the public sphere and intellectual and professional scene is not welcomed by both "the secular intellectual and cultural elite and the more conservative community" (p.316).

In her holistic report named "Headscarf Ban and Discrimination: Professional Headscarved Women in The Labor Market," Cindoğlu (2011) analyzes the headscarf ban through its implications on public and private sector employment. She aims to reveal the numerous forms of discrimination and rights violations women face due to their headscarves in the labor market. The report's main finding is that the headscarf ban in the public sector spilled over to the private sector and posed a challenge for veiled women in recruitment, wage policies, work performance, and promotions. Cindoğlu (2011) points out the incremental impact of the headscarf ban on women and the whole society by asserting that:

> In a society where educated women are not allowed access to the labor force, the creativity, productivity and solution-oriented thinking that come with the female labor force cannot be taken advantage of. Moreover, in a world where women are unable to join the labor force, there is no chance of shifting the balance in women's favor in terms of the traditional, domestic division of labor characterized by a male-dominant nature, where the role assigned to the woman is supporting the man by taking care of household chores while he provides for the family. (p.9)

Cindoğlu considers the headscarf ban through the representation of women in the labor market. The main obstacles to women employees are, according to Cindoğlu, "internalized patriarchal values and traditional gender roles" and "gender-based discriminatory and abusive practices in the job market stemming mostly from the established patriarchal values, which discourage women from working" (p.13). Furthermore, she adds what is missing in the literature is the impact of the headscarf ban. She asserts that the fundamental factor restraining women from entering the workforce is not their religiousness or traditional family roles but the headscarf ban in the public sector and its spill-over effect on the private sector. Her study successfully reveals the hardships of veiled women working in private sector jobs during the headscarf ban comprehensively and brings a new approach to the discussion on headscarf within women and work framework.

Similarly, Karaca (2013) examines the headscarf ban's impact by focusing on the employee-employer relationship in business life. Since veiled women could not work in public sector jobs due to the headscarf ban, they tended to apply for private-sector jobs. Not all businesses are willing to hire these women, but conservative ones do. Taking this as a starting point, Karaca concentrates on conservative businesses and

veiled women's working conditions in them. She concludes that veiled employees face challenges in hiring, wages, and promotion in these organizations.

Among others, she emphasized that in conservative businesses, the veiled employee's visibility is negotiated through the customers' perceptions of the headscarf. In other words, veiled employees are "present" or "absent" according to the business plan. In the long term, this results in the exploitation of labor since these women who do the work have to remain absent and could not get credit for their job success. Her study also reveals that rather than supporting veiled women and providing decent working conditions, conservative organizations implicitly discriminate and exploit veiled women through giving them lower wages, making them work longer hours than required, and limiting their rights as employees.

Furthermore, in her book named *Beyond Headscarf Culture in Turkey's Retail Sector*, Sayan-Cengiz (2016) profoundly analyses the negotiated meanings of the headscarf among lower-middle-class, non-university-educated women working in the private sector in Turkey. She finds that covered women in retail sales jobs negotiate their headscarves for security and status in the insecure labor market. Therefore, the headscarf obtains a meaning related to class and status instead of religiosity and identity. These connotations play in patriarchal bargains and aspirations for higher status jobs.

Sayan-Cengiz (2016) asserts that "the problems of workplace democracy and encroachments of patriarchy at work" are essential in understanding the categorization of women with headscarves as a specific type of labor force; not "the Islamic and secular divide" (p. 7). It is vital since she provides an alternative way of discussing women with headscarves, emphasizing patriarchy, and other related structures at work. Her study reveals the significance of class, status, and education level in determining the headscarf's role in a woman's life. Unfolding the collective category of "women with headscarves," Sayan-Cengiz proves that there are different subjectivities and forms of engagement with the headscarf. Focusing on the covered women in private sector jobs reveals the "informal way of excluding women with headscarves from being employed in certain settings" for the sake of market rationality and private

managerial concerns (p.151). She provides valuable insight that the headscarf affects how women with headscarves establish their work-life.

Unlike the studies analyzing the women in the workforce, Marshall (2005) examines feminist and Islamist women's perspectives on headscarf and work. Her study is significant since it reveals the approaches of Islamist women to work. She states that headscarf and work are interrelated since "a woman's opportunity to do paid work in Turkey is contingent on her decision to cover or not to cover her head in the public sphere." (p. 105).

She groups Islamist women into two as reformist and orthodox and describes their approach to work. Reformist Islamist women claim that women can work if they want to, and they should aim to serve society, not to satisfy personal desires. Orthodox Islamist women, on the other hand, do not support the work of women. They argue that women should stay at home and fulfill their duties as mothers and wives.

It should be noted that these studies on women with headscarves at work were done when the headscarf ban was in force. Only Sayan-Cengiz's (2016) held her research after the abolition of the ban. However, the focus of her study is private-sector jobs. Therefore, as far as we know, there is no previous research investigating the state of veiled women in the public-sector after the abolition of the headscarf ban. Nonetheless, previous research could be considered a steppingstone before a more profound understanding of the experiences of women with headscarves at work.

2.2 Medical Work, Women, and the Headscarf

2.2.1 Medical Work from a Gendered Perspective

There is no doubt that gender has a significant impact on medical work culture, practice, and organization. However, female health professionals' specific situation in the medical workplace had been neglected until feminist scholars (Lorber, 1984; Witz, 1992) have entered the field. These scholars mainly discussed the issue through the concept of patriarchy and revealed how structural mechanisms, discursive strategies,

and social closures keep women from entering the medical profession and hinder their career advancement.

The sociological literature on women in medicine mainly focuses on women's position as professionals in the gendered healthcare workplace (Witz, 1992; Davies, 1996; Cockerham, 2009). Apart from sociology, gender in medicine has been studied by scholars from different disciplines such as medicine, psychology, and business (Firth-Cozens & Harrison, 2010; Kilminster et al., 2007; Serrano, 2007; Hall & Roter, 2002; Roth et al., 2016; Kuhlmann & Annandale, 2012). The focus of the studies on healthcare professionals is mainly nurses (Allen, 2001) and midwives (Declercq et al., 2001) since these groups together constitute a significant portion of the female healthcare workforce and encounter more discrimination based on gender and knowledge (Witz, 1992; Macdonald, 1995). Yet, few scholars have also pointed out the state of women physicians (Riska, 2001; 2009; 2014).

Although women struggled to enter the medical profession, the number of women physicians increased in time for two reasons. First, due to educational developments, more women receive university-level education. In fact, the majority of university graduates in many western countries are women, as Kuhlmann and Annandale (2012) argue. Secondly, the healthcare system's expansion resulted in a growth in medical schools to meet the need for more healthcare professionals. Consequently, more women have been registering to medical schools and becoming physicians, leading to the feminization of the medical profession.

Feminization is defined as the flow of women towards occupations that are previously male-dominated. In time, women continue to dominate occupations such as nursing and midwifery and increase their participation in male-dominated medical occupations, namely medicine, dentistry, and pharmacy. In short, the number of women in healthcare professions has increased.

Despite the increase in female physicians' percentage, discriminatory practices, gender segregation, and structural barriers within the profession continue to put women in disadvantageous positions. In this connection, examining women physicians' career advancement is a convenient way of tracking the discriminatory practices and behaviors in the medical workplace.

A robust literature is available concerning women physicians' career advancement (Epstein, 1970; Lorber, 1984; Riska, 2001; Crompton & Lyonette, 2011; Burke & Mattis, 2005; Fried et al., 1996). The discussions on women's careers in medicine gather around the argument that women mainly work in niches of the health care system or medical specialties characterized by relatively low earnings or prestige.

Kilminster et al. (2007) argue that gender segregation is ubiquitous in healthcare and has two types. In horizontal segregation, men and women hold the same job title but do different jobs. In other words, women are concentrated in certain specialties such as obstetrics and gynecology or pediatrics. On the other hand, Roth et al. (2016) explain vertical segregation as women being underrepresented at administrative positions such as medical professors, medical directors, or chief physicians.

A bulk of research reveals that men and women physicians have different specialty choices based on their gender-related responsibilities and characteristics. According to Ku (2011), male and female medical students have different specialty aspirations while entering medical school. As students graduate from medical school, their specialty choices are reoriented by gender-based factors such as concerns of balancing work-family life, presence of encouragement and mentoring, wage concerns, and the like.

One perspective explaining the differences in specialty choices between female and male physicians is the gender socialization perspective. According to this perspective, men and women acquire sex roles through socialization in society and gender division of labor in the family and labor force. In this respect, women physicians prefer family-friendly specialties that fit their traditional female gender roles. In this way, as Crompton and Lyonette (2011) put it, they can balance their work and family life, and they have time for domestic work and caring responsibilities. In this manner, women physicians tend to practice in primary care areas or specialties with regular working hours and less nigh duties that focus on children, women, or the elderly. On the other hand, labor-intensive specialties with higher prestige and wage, such as surgery, are chosen mainly by men. Due to the nature of these specialty areas, women earn less than their male counterparts in other specialties (Riska, 2001, p.50).

Moreover, another perspective focuses on structural factors and claims that sexual harassment, lack of mentors and role models, collegial support, information, and professional networks form a glass ceiling that discourages women from building a career (Riska, 2014, p.3).

Finally, a third perspective focuses on gender dispositions in explaining gender differences in specialization areas and argues that women physicians make their preferences according to their gender skills (Ulstad, 1993, p.75). this literature emphasizes specific female characteristics and their impact on specialization choices and overlooks the discriminatory structures in the medical workplace.

Riska (2001), in her book titled *Medical Careers and Feminist Agendas: American, Scandinavian, and Russian Women Physicians*, questions how women's status as professionals has been formed in different settings by looking at the history and current position of women physicians in three different cultural and political contexts. She finds that the conditions and influence of women physicians differ according to the health care systems determined by the political and economic context of a country. Thereby, she argues, tracing women physicians' professional lives provides a framework of the scientific, professional, and organizational transformations of medicine. She observes that women make career decisions according to their family life, even in societies where gender equity is achieved. Also, she reveals how women physicians legitimize their specialization choices through strategic essentialist claims on their special gender skills and values. She concludes that structural forces and gender approaches in medical organizations will continue to hamper women's careers, and women physicians will continue to employ strategies to tackle these problems.

Her work is significant since it provides a systemic assessment of theoretical perspectives and concepts explaining women physicians' career advancement across diverse societies. From a sociological perspective, she explains three approaches for interpreting women's position in medicine: contingent, embedded, and essentialist. According to the contingent approach, organizations are gender-neutral, but the historical and cultural circumstances give a gendered character to a profession. Therefore, as more women enter the medical profession, gender inequalities would be eliminated. Secondly, the embedded approach claims that the medical profession has

structural and cultural masculinity in its essence. This gendered nature comes with gendered processes and practices. Thirdly, according to the essentialist approach, gender is embedded in any organization. Medicine has a patriarchal culture, and women are left out of this structure.

In the same way, studies on gender characteristics of physicians give clues about the medical specialty choices and the general state of women physicians. First, it should be mentioned that there is no significant difference between male and female medical students' academic performance. As Kilminster et al. (2007) reveal, if there are any gender differences in motivations or attitudes, they tail off in time, mostly during medical education.

Although female and male physicians have similar medical knowledge and academic performance levels, their communication patterns and practice styles differ. In terms of communication skills, women physicians are more empathetic, nurturing, and compassionate in practice than their male counterparts (Kuhlmann & Annandale, 2012; Roter & Hall, 2004). Women physicians are more patient-focused and collaborative, spend more time with patients, and care about their psychological well-being. In return, patients speak and explain more to female physicians and interrupt them more (Hall & Roter, 2002, p.221).

Regarding the practice styles, according to Bertakis (2009), women physicians are tended to practice in primary care and provide more counseling than their male counterparts. Bowman, Frank, and Allen's (2002) argument is explanatory at this point. They assert that "the field of medicine is actually one where both traditional male and female attributes are frequently desired -patients want physicians who are capable and decisive (traditional male), but caring and warm (traditional female)" (p.73).

Demand for female physicians also affects the state of women physicians in the medical workplace. Patients' preference for a physician depends on several issues such as religion, culture, communication skills, and medical knowledge. Nevertheless, a bulk of research confirms that the preference of same-sex physicians is common in all contexts (Uskul & Ahmad, 2003; Adams, 2003). In societies where social tradition and religious beliefs have a significant role, women prefer same-gender physicians,

especially for intimate examinations such as obstetric, gynecological, and breast (Aldeen, 2007; Matin & LeBaron, 2004; Zuckerman et al., 2002).

There is a broad literature on women patients' obstetrician and gynecologist preference, especially in Muslim countries (Aldeen, 2007; Lafta, 2006; Uskul & Ahmad, 2003). Lafta (2006) finds that social tradition and religious beliefs direct women to female physicians for examination. However, as the level of education and age increases, this preference gradually diminishes. On the other hand, McLean et al. (2012) state that female patients prefer women gynecologists irrespective of educational status. However, women with higher education are more relaxed with a male physician in other examinations.

Contrarily, Demirgöz-Bal et al. (2014) find no direct impact of religious beliefs on a physician's gender preference of women patients. Instead, socio-cultural factors weigh more, such as women physicians' communicative skills, feeling comfortable with a female physician's presence, and embarrassment.

A physician's skills outweigh his/her gender, and if a male physician has more experience and medical knowledge, he is preferable for women patients. Bowman, Frank, and Allen (2002) argue that women patients prefer male physicians, particularly obstetricians or gynecologists if their technical competence is recommended.

Sexual harassment and gender discrimination are widespread in the medical workplace. According to the literature, gender bias and sexual harassment are the main obstacles that prevent female physicians from achieving their full potential. In a parallel vein, Serrano (2007) states the challenges female physicians face as gender bias and sexual harassment, a scarcity of female mentors in leadership positions, and work and family conflicts.

It is fundamental to clarify the concepts of harassment and discrimination. Besides physical harassment, verbal remarks and actions are counted as harassment when unwanted and create a hostile work environment or adverse employment decisions (Bowman, Frank & Allen, 2002). Harassment occurs in the form of belittlement, public humiliation, taking credit for someone's work, and psychological and physical abuse from colleagues, patients, and families.

On the other hand, gender discrimination is identified as gender-based behaviors and actions that cause disparate treatment and an intimidating environment for both genders in the workplace. In general, sexual harassment and gender discrimination cause poorer psychological outcomes, self-reported lower self-confidence, lower self-esteem, impaired ability to learn, lower career satisfaction, and lower professional confidence.

In their study, Frank, Brogan, and Schiffman (1998) examined the prevalence of harassment among women physicians. They revealed that both gender discrimination and sexual harassment are more common during training, which covers medical school, internship, residency, and fellowship, than during practice. The importance of hierarchy establishes a setting in the medical profession where harassment occurs frequently. Since students in medical schools are lower in the hierarchy than their professors, they might be harassed more, and since women physicians hold higher positions in the hierarchy, they experience relatively less harassment.

Likewise, Beagan (2001) reveals that female medical students tend to experience gender discrimination and sexual harassment more than male students, making them feel more marginal in medical school. While explaining the types of gender discrimination, she argues that "male students being called doctor while women are not, women being mistaken for nurses, being called 'girls', being ignored by instructors" are signs of gender inequality in medicine (p.585).

Carr et al. (2000) analyze the faculty perceptions of gender-based discrimination and sexual harassment and found that women professors perceived more gender bias in the academic environment than their male counterparts; suspected or felt clear that they had experienced gender bias in professional advancement; reported having been sexually harassed by a superior or colleague. Nevertheless, at the same time, they felt that gender had given them an advantage in professional advancement. It is important to note that women who reported experiencing negative gender bias had lower career satisfaction, which affects their overall status at work.

Mobbing is a serious threat to medical workers' physical and mental health and is very frequent in the health sector due to the high number of women. Kingma (2001) shows that healthcare workers are 16 times more likely to be mobbed than other service

industry workers. Moreover, there is broad research arguing that women are more prone to the risk of violence than men, mainly when they work at unstable, uncertain, low-wage, and low-status jobs (Di Martino et al., 2003). Karsavuran (2014, p. 291) confirmed that women in executive positions in the health sector are exposed to mobbing more than their male counterparts.

2.2.2 The State of Women Physicians in Turkey

Woman in the health sector in Turkey has been studied widely, but the focus is predominantly on women at lower levels of the hierarchy, such as nurses and allied health personnel (Urhan & Etiler, 2011; Ciğerci-Ulukan & Özmen-Yılmaz, 2016), since nurses and midwives comprise a significant portion of health staff. Only a few studies focused on the state of female physicians who hold higher positions in the health care system (Genç-Kuzuca, 2007; Bayrakçeken-Tüzel, 2004; Yapıcı et al., 2010, Bekata-Mardin et al., 2000).

Before moving to the work characteristics of women physicians in Turkey, addressing the statistical overview will help have a better understanding of the state of female physicians in Turkey. According to TurkStat, health personnel's employment rate, especially physicians, nurses, and emergency medical technicians, is 75.4%. The unemployment rate in the health sector is 9.6%. Hence, it can be said that the employment rates are high in the health sector.

Regarding the rates of students and teaching staff in medical schools, it can be said that gender equality is achieved in medical education since the numbers of male and female students are similar. According to the Council of Higher Education statistics (n.d.), in the 2018-2019 academic year, 49.5% of new admissions to medical schools are female. Compared to the 2013-2014 academic year (47.5%), both the number and the ratio of female new entrants increased. The percentage of currently registered female students is 49.4%, which is promising compared to 43% in 2000 and 41.3% in 2006.

However, the teaching staff at medical schools still face gender inequality. Last year, women represented 43.5% of the teaching staff, including professors, associate

professors, assistant professors, instructors, and research assistants. Among these, the most significant gender gap is observed among professors. Within 7203 professors of medicine, women's rate is only 34.7% compared to men with 65.3% in the 2018-2019 academic year. What is promising is that this gender gap is on the decline. In the 2013-2014 academic year, men represented 68.5% of professors in medical schools while women constituted 31.5%.

According to Bekata-Mardin et al. (2000), a large number of women in the sector, the Examination for Specialty in Medicine (TUS), and a large number of women in executive positions may cause a misperception that there is gender equality in the health sector in Turkey. As mentioned before, although the quantity of female workers is a credible indicator of female employment in the health sector, this employment's quality tells much about the state of women.

While discussing gender discrimination during medical specialization in the Turkish context, the TUS should be emphasized. After six years of education in medical school, a medical student becomes a practicing physician. If s/he wants to be a specialist, s/he should pass the TUS and receive extra 4-6 years of education on the medical specialty which s/he selects according to exam results.

What is interesting here is that TUS was introduced in 1987. Before this date, each faculty of medical specialty made their own oral and written exams. According to Genç-Kuzuca (2007), there was no mechanism to control the validity of the exam results. Therefore, discriminative decisions prevent certain students from becoming a specialist in that area. She argues that "it is known that some universities and some departments never accept female assistants in these exams. The perspective of the head of the department can be an indicator of whether the female physician will be employed as an assistant or not." (p.23)

Owing to TUS, discrimination against female physicians is prevented to some extent. To demonstrate, 68.2% of the participants of Yapıcı et al.'s (2010) study state that the introduction of TUS promoted specialization among women physicians.

Mechanisms other than TUS push women physicians to select specialties "suitable for women." Guidance of medical professors and family members and attitudes of male

colleagues are some examples of these mechanisms. Toksöz (2007) argues that in some male-dominated specialties with heavy working conditions, male physicians' negative and discriminatory attitudes urge women physicians not to choose these specialties.

Also, keeping work and family balance is a central motivation for women physicians in selecting a specialty. Mostly, they prefer less-exhausting specialties with less workload (Urhan & Etiler, 2011, p.203). Some typical features of these specialties are having less night duty, less interaction with patients, with intensive care units (Genç-Kuzuca, 2007). Therefore, it can be said that women physicians are mainly concentrated in basic medical sciences. In surgical sciences, the rate of women physicians is shallow. Gediz-Gelegen (2002) reveals that women physicians are mainly employed in specialties so-called suitable for women: dermatology, physical therapy and rehabilitation, pediatrics, obstetrics and gynecology, and ophthalmology. It should also be noted that a considerable number of women physicians choose to become a practicing physician, not a specialist, due to the reasons stated above (Yapıcı et al., 2010, p.24).

Genç-Kuzuca (2007), in her comprehensive study, questions the presence of gendered approaches that result in gender-based discrimination during medical education and specialization in Turkey. She concludes that despite the TUS, gender discrimination still exists in medical specialization stemmed from the gender perspective of the faculty or the specialty preferences of female physicians. For instance, in nearly half of the 28 specialty areas, women represent below one-third of physicians, which is regarded as a critical threshold for gender representation. Given these points, it is argued that women physicians prefer specialties with moderate working conditions and less income while men work in specialties with heavy working conditions and higher income.

By and large, women experience gender-based discrimination at different stages in different forms from their colleagues, professors, allied healthcare staff, and patients. Some studies have specifically examined the violence against women workers in Turkey's health sector (Aytaç & Dursun, 2013; Aytaç et al., 2011; Uncu, Bayram & Bilgel, 2006; Karsavuran, 2014).

Yapıcı et al.'s (2010) study reveals that women physicians encounter discrimination mostly during practice (57.7%). Only 33.3% of respondents assert that they face discrimination during education and residency. Practicing physicians are subjected to discrimination more (73%). Patients and their relatives (80.9%) are primarily responsible for discrimination against women physicians and followed by colleagues (49.4%).

The research of Bekata Mardin et al. (2000) successfully reveals the state and status of women in the health sector. They argue that although the health sector is female-dominated, women occupy lower ranks. They observe gender inequality in specialty, status, wage, and competition. They find that 54% of female physicians and 73% of executive women reported gender-based discrimination in their workplaces. That is to say, women in the executive position felt discriminated against more.

Work-family balance is more difficult to obtain in the health sector. Furthermore, it is found that the workload in the health sector affects women's private lives more negatively than men. They found that women in the health sector experience discrimination while selecting a specialty, practice, and building careers. What makes this study valuable is that other discrimination types are mentioned as well. Discrimination based on occupational status, political view, religious belief, personal relations with administration negatively affect health personnel. Combined with gender, discrimination due to the aforementioned issues makes women vulnerable in the health sector.

In a similar vein, Aytaç and Dursun (2013) study workplace violence in the health sector, find that women experience or witness physical or emotional violence in the medical workplace. According to the research findings, 55.7% of participants experience violence in the workplace. Verbal violence is the most common type of violence, with 49.9% and followed by emotional pressure and intimidation with 39.1%. Although exposure to physical violence (5.8%) and sexual violence (2.4%) are low, this violence's impact on women is critical. The physical violence is directed from mainly male patients or relatives of patients, whereas emotional pressure and intimidation mostly come from female colleagues. Also, it is mostly male colleagues who exert verbal and sexual violence against women.

Diverges from the literature on workplace discrimination based on gender in medicine, Bilgel, Özçakır, Sadıkoğlu, and Aytekin's (2011) research claims that women physicians do not think that they experience gender discrimination at the workplace. According to this study's findings, over 70% of the participants think that they are not subjected to gender discrimination. Likewise, most participants reject that they are lower paid, excluded from decision making, precluded from career development, and exposed to sexual abuse.

However, it should be stated that practitioner physicians experience these types of discrimination more than specialist women physicians. On the other hand, work-family balance is essential for women physicians, as 88% of participants argue that keeping this balance is very crucial for their career. Plus, over 70% of participants think that they cannot balance work and family life.

There are few studies addressing gender differences among physicians in Turkey (Özçelik, Surucuoglu & Akan, 2007; Sarp, Yarpuzlu, & Onder, 2005; Özyurt, Hayran & Sur, 2006; Uncu, Bayram & Bilgel, 2006; Burke, Koyuncu & Fiksenbaum, 2009) These studies focus on gender differences in knowledge, job satisfaction and burnout, job-related well-being and stress, anxiety and depression, and work experiences. Interestingly, no gender differences are found in these areas. Contrary to what one may expect, gender has nearly no impact on physicians' overall well-being at work. However, none of these studies specifically focus on the state of female physicians.

However, there are specific variations in the way of work among female and male physicians. "Female physicians spend more time with patients, perform more preventative services, and are often perceived as more compassionate and conscientious" (Burke et al., 2009, p.77). Uskul and Ahmad (2002) find that male physicians use more distant hierarchical communication while female physicians use more egalitarian, empathetic communication, and are more likely to describe diagnoses and treatments in non-technical language. Women at the workplace report more discrimination and sexual harassment than men (Burke and Mattis, 2005).

Burke et al.'s (2009) study reveals the commonalities and differences among female and male physicians regarding working characteristics and conditions. What makes this study interesting is that unlike other studies on gender differences in different

occupations, this study finds no significant gender differences on personal demographic and work situation characteristics.

They reveal that women and men share almost the same personal demographic characteristics, stable individual difference personality factors, organizational work-life experiences, job behaviors, work outcomes and levels of work engagement, quality of life, and psychological well-being. However, women physicians spend fewer years in the profession than their male colleagues, have more work-family conflict, worked fewer hours, indicating higher levels of psychosomatic symptoms, and tended to be absent more. The study argues that physicians' structure of the medical work environment prevents gender-based differences to some extent compared with other professions.

In sum, gender differences among male and female physicians are found in specialization, working hours, and earnings, in which women are in disadvantageous positions.

All the studies that I elaborate on the above aim to explore gender discrimination and challenges women physicians face in the medical workplace. However, the headscarf and related dimensions are missing. Since the headscarf was a critical issue for a woman to receive an education and have a job for many years in Turkey, discrimination due to headscarf during medical education and practice should also be researched. This thesis aims to fill this gap in women and work literature.

2.2.3 Women Physicians with Headscarves

Various disciplines have studied the state of women physicians with headscarves from business and medicine to sociology (Zainal & Wong, 2017; Masood, 2019; Abu-Ras, Senzai, & Laird, 2012; Reeves & Azam, 2012; Padela et al., 2016). Studies on workplace discrimination have primarily focused on gender and race, with few analyzing the impact of religion on discrimination.

Workplace discrimination within the physician workforce due to Islam has been widely studied primarily in the post-9/11 era in the United States within the concept

of being a Muslim physician in Western context because American Muslims have started to face significant prejudice and discrimination which spilled over the health care workplace (Padela et al., 2016; Abu-Ras, Senzai, & Laird, 2012; Nunez-Smith et al., 2009).

On the other hand, several studies discuss the issue within the Islamic context and examine the impact of Islamic values and traditions on the work-life of covered physicians in Muslim societies. (Ahmed & Mohamed, 2006; Azarmina, 2002; Masood, 2019), in addition to the studies examining the discrimination covered women face in the workplace in general (Ali, 2013; Sidani, 2005; Syed, 2008; Syed, Ali & Winstanley, 2005).

In their study, Reeves and Azam (2012) examine Muslim women's self-identification, perception of workplace discrimination, and workplace involvement in the United States. Adopting the discrimination and stigma literature, they aim to uncover the religious representations and their effects on Muslim women working in healthcare organizations. A veiled woman's religious belief is visible through her clothing. Therefore, they are claimed to encounter more stigmatization and discrimination in the workplace.

Moreover, this stigmatization results in the loss of status. According to the expectation states theory of Berger, Cohen, and Zelditch (1972), both known information and implicit assumptions based on specific characteristics lead to a person developing an assessment of another's abilities, skills, and values. In other words, the hierarchy within the group is mostly influenced by the effect of social cues that are often guided by stereotypes of race, gender, age, class, and looks on the assumptions.

Being a female physician with a headscarf, in this case, may push these physicians to the lower levels of social hierarchies in the workplace. Reeves and Azam (2012) explain this situation as follows: "Control over and demonstration of expertise by providing health services is such a reward for physicians. Anything that impedes their ability to provide health services directly challenges physicians' professional status and standing" (p.43). They argue that if a patient refuses treatment from a physician because of her stigmatizing characteristic, it will be a real threat to the physician's professional status and power.

Highlighting physicians' higher status, Reeves and Azam assert that physicians are influenced by religious bias more than nonphysicians in the workplace. Additionally, not allowing a veiled physician to practice her profession because she was stigmatized also undermines the physician's professional status and power, and thus career.

Turning to the question of stigmatization through the headscarf, Reeves and Azam argue that a woman physician with a headscarf is always in a struggle over the preconceived stereotypes of her colleagues of Islam and Muslim women in particular in the workplace. Therefore,

> Wearing hijab becomes identity "deployment" that "has the principal effect of politicizing the personal" (Creed & Scully, 2000, p.394) through clothing choice, with the result "that the values, categories, and practices of individuals become subject to debate" (Bernstein, 1997, p.537-38) related to the group. For example, if an hijabi's performance at work should be sub-standard, other people may associate poor performance with being Muslim, even if performance and religious conviction are unrelated. Thus, the hijabi risks corroborating or elaborating negative stereotypes through her clothing choice, in addition to any personal risks she may incur (p.44).

Equally important, Zainal and Wong (2017) critically examine the everyday struggles of veiled women working in Singapore's public healthcare organizations focusing on female Malay-Muslim nurses with headscarves to uncover the multiple layers of discrimination they face. In a country that is multiracial and secular, the headscarf is perceived as a "traditional Malay image" and a "traditional marker" standing against the "modernization project" that the Singapore state engages (p.109-110).

Based on this, Zainal and Wong find similarities between Singapore and Turkey in terms of their treatment of the headscarf. They argue that both states attempt to control and regulate religiosity in everyday life and perceive the headscarf as a direct attack on the political elite's legitimacy and secularism.

Zainal and Wong's study distinguishes itself from previous literature by concentrating on the "lived experiences" of veiled women at the workplace rather than discussing the issue solely through a secular-religious binary. Therefore, the state's politics and practices regarding gender, race, religion, class, and multiculturalism would be successfully grasped. In this manner, Zainal and Wong find that while women physicians are allowed to wear the headscarf at work, nurses are banned from wearing

it. This reveals the class-orientation of the policies that the Singapore government makes.

To conclude, they argue that social class, economic and educational backgrounds are equally crucial in shaping religious beliefs, and this determines the perspectives of the veiled women on the headscarf. Therefore, women's exposure to the headscarf ban and their experiences regarding discrimination at the workplace vary, requiring a new approach rather than multiracial ideology.

Finally, Masood's (2019) study uncovers how women physicians with headscarves are marginalized through the norms of conduct, international ethics, organization of physical space, and work allocation in the workplace in Pakistan. She argues that the patriarchal interpretations of religious doctrines of the headscarf limit the participation of veiled women in the public sphere, resulting in occupational segregation of men and women.

In this connection, women are expected to do "women's work" to meet "women's needs" or to have feminine professions such as nursing and teaching. While elaborating on the state of physicians, she asserts that "women doctors' inclusion in the medical profession is premised on the notion that they are needed to serve women patients (who will not see a man physician) and to take care of feminine problems (read: gynecology and obstetrics)" (p.216).

According to the inequality regimes theory of Acker (2006), there is a "set of intersecting and overlapping processes that create systemic inequalities based on a certain performance of gender, class, and race" (p.217). Adopting this theory, Masood emphasizes that the gendered substructure of the headscarf in organizations legitimizes inequality regimes and deepens it. She notes that although wearing a headscarf is an individual practice, it is "institutionalized through various social, material and religious gender segregating policies and practices" (p.218). Moreover, the veiled women's experiences in the workplace are numerous due to the complex social systems, and therefore, the headscarf establishes different subjectivities in the workplace.

In light of the information above, it can be argued that veiled Muslim women in the health sector have diverse experiences regarding the headscarf based on the social, political, and cultural context of a country. The Health system, tradition, and religious beliefs in a country also affect veiled women's experiences in the health sector. Nevertheless, veiled Muslim women face individual discrimination based on gender and religion in every context. While the discrimination stems from the political atmosphere and labels veiled women as terrorists in a non-Muslim community, this discrimination is a result of patriarchal institutional norms and religious beliefs in a Muslim country.

Among the studies above, the state of Malay Muslim nurses, Zainal and Wong's focus, has several points in common with the veiled Turkish women's experience. Since both countries are secular, the perspectives of the headscarf and implementation of secular principles against the headscarf are similar. Secondly, parallel to Reeves and Azam's (2012) arguments, people could quickly stigmatize veiled physicians because of the headscarf. As a result, the stigmatization might threaten the status of veiled physicians who hold higher professional positions in the medical workplace. This thesis also examines the presence of this stigmatization in the medical workplace in Turkey, if any.

CHAPTER 3

RESEARCH DESIGN

This chapter presents the research design of the thesis. First, I explain the starting point of the thesis and the research question. Secondly, I describe the research method. In this thesis, I utilize the qualitative method and conduct in-depth interviews with 21 physicians with headscarves working in Ankara's public health sector. I discuss the content, the timing, the places of the interviews, and the sample design in the second part. Following that, I examine the field. I address the reason for choosing public health institutions and reveal the inner workings of these institutions. I give detailed information about the sample in the participant profile section. After discussing the thesis's conceptual framework, I end the chapter with the advantages and limitations of the research study.

3.1 Research Question

Being a witness of the headscarf ban and the related problems women with headscarves face in education and work-life directed my research to women's study and work environment with headscarves after the abolishment of the headscarf ban. The headscarf ban and the related problems veiled women face have been studied extensively by numerous scholars from different disciplines. The political, economic, and social impacts of the headscarf ban on women and society have been uncovered in previous studies. In 2010, the ban was lifted in universities, and in 2013, the headscarf became free in public institutions in Turkey. Thus, women were able to go to universities and work in public institutions with the headscarf. Then, what happened? Were the effects of the years-long ban eradicated in a short time? Did the problems women face suddenly disappeared, and women with headscarves become

parts of the public education and employment without hesitation? It is no surprise to assume that women are trapped in gender discrimination in their workplace environment. However, does the headscarf itself exacerbate this discrimination?

In this connection, the main research question that I seek an answer throughout the thesis is "How the headscarf issue shaped the experiences of women physicians with headscarves in the public health sector after the abolition of the headscarf ban in Turkey?" I also try to find answers to the following sub-questions: How and in what ways does the headscarf affect veiled physicians' work-life? How and to what extent the prior headscarf ban affects the work-life of female physicians? For instance, does it impact veiled physicians' decisions on selecting their occupation, their field of specialty, their workplace, and the like? What specific do explicit and implicit barriers to progression veiled physicians identify at different stages in their careers? I selected women physicians with headscarves as the focus of this thesis for the following reasons: the medical profession is a high socio-economic status profession and requires intellectual prowess while necessitating physicians to do compulsory medical service in public health institutions to become a physician. Therefore, a physician with a headscarf stands at the intersection of political, social, and professional conflicts.

By documenting the answers to these questions, this research will provide information on how the headscarf shape and influence the physicians' work lives; observe the role of the headscarf in influencing the relations within the medical workplace, including physician- physician, managers, allied health professionals, and patients relations; and give insight about the factors affecting veiled physicians' decisions of employment in different specialties.

The headscarf's roles and meanings in their work-life as working women in intermingled hierarchical public workplaces at the intersection of gender, class, and religious identity have not been discovered yet in Turkey. This thesis focuses on middle-class, university-educated women to uncover the workplace experiences and adaptation process of veiled women to their workplace. To this end, veiled physicians are chosen as the unit of observation.

There are various reasons for focusing on women physicians with headscarves in Turkey's public health institutions in this study. First, the medical profession is

prestigious. It requires hard work, dedication, and altruism. Getting high scores in university entrance exams and years of intense education in medical school are followed by intense work pressure and stress. After four years of theoretical classes at the university, students of medicine start working in hospitals as interns with their professors to practice in the field for two years. After their six-years-of medical education, they graduate as practicing physicians and have to do conscription in public health institutions, mostly in Eastern Turkey. To become a specialist physician, physicians should take the Examination for Specialty in Medicine (*Tıpta Uzmanlık Sınavı*). After that, they have to receive four years of specialty education in a public health institution through professors' training and examining patients. After that, they have to do conscription again. Physicians have to study and work in public institutions for a specific period to work and make progress in their profession. Considering this, almost all female physicians in Turkey faced the headscarf ban in their educational lives and work lives - if they did not prefer to work in private health institutions - and this constitutes the second reason for studying this issue.

3.2 Research Method

To investigate the questions mentioned above, I have followed qualitative research methods because the researcher makes the world visible through qualitative research. The social reality can be grasped in representations such as interviews, recordings, and the like. Denzin and Lincoln (2005) argue that

> At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (p.3).

In other words, I have adopted a qualitative research technique in this study to understand veiled physicians' experiences, feelings, and perceptions in the formerly prohibited public medical workplace and to document a detailed description.

Among the qualitative research methods, I have primarily utilized the in-depth interview method. As Kümbetoğlu argues (2008, p.72), the interview is a data collection tool that aims to grasp the details and get to the core of the various

phenomena, processes, and relationships in the social world with a holistic understanding. In-depth interviews are used in field research and require asking questions, listening, showing interest, and recording what is said (Neuman, 2014, p.353). Through in-depth interviews, I discovered perceptions, interpretations, and evaluations of the participants.

Within the scope of the research, I have conducted in-depth interviews with 21 female physicians with headscarves working in public health institutions over a period of approximately two months, from February to March 2020. During the interviews, the main objective was to understand the causes, consequences, and means of headscarf-related experiences of women physicians in the context of medical work.

This study is based on the findings gathered from women physicians with headscarves working in some public health institutions in Ankara. These institutions are: Ankara City Hospital (*Ankara Şehir Hastanesi*), University of Health Sciences Ankara Gülhane Training and Research Hospital (*Sağlık Bilimleri Üniversitesi Ankara Gülhane Eğitim ve Araştırma Hastanesi*), Yildirim Beyazit University Yenimahalle Training and Research Hospital (*Yıldırım Beyazıt Üniversitesi Yenimahalle Eğitim ve Araştırma Hastanesi*), University of Health Sciences Ankara Dr. Sami Ulus Women, Children's Health and Diseases Training and Research Hospital *(Sağlık Bilimleri Üniversitesi Ankara Dr. Sami Ulus Kadın Doğum, Çocuk Sağlığı ve Hastalıkları Eğitim ve Araştırma Hastanesi*), University of Health Sciences Ankara Keçiören Training and Research Hospital (*Sağlık Bilimleri Üniversitesi Ankara Keçiören Eğitim ve Araştırma Hastanesi*), Ankara Keçiören Sanatorium Atatürk Chest Diseases And Chest Surgery Training And Research Hospital (*Ankara Keçiören Sanatoryum Atatürk Göğüs Hastalıkları ve Göğüs Cerrahisi Eğitim ve Araştırma Hastanesi*), University of Health Sciences Dışkapı Yıldırım Beyazıt Training and Research Hospital (*Sağlık Bilimleri Üniversitesi Dışkapı Yıldırım Beyazıt Eğitim ve Araştırma Hastanesi*), Beytepe Murat Erdi Eker State Hospital (*Beytepe Murat Erdi Eker Devlet Hastanesi),* three different Family Health Centres, and one public institution in Ankara.

As stated above, qualitative research's main objective is to understand and define the reality provided by the informants themselves as directly as possible. Therefore, "what" and "how" questions are asked to participants during interviews instead of

"why" (Kümbetoğlu, 2008). Therefore, I have prepared the interview questions with what and how questions in four headings: introduction, the headscarf ban, medicine, and hospital. Interview questions are semi-structured and open-ended, enabling a non-directive interview and giving participants a comfortable setting to freely express their feelings. The face-to-face semi-structured interviews lasted an average of 40 minutes, the shortest being 17 and the longest 76 minutes.

I have utilized the snowball sampling technique to detect 21 physicians with headscarves working in Ankara's public health institutions. I have found first participants through my contacts such as friends, relatives, and acquaintances eligible for the research. After reaching a few contacts through such an approach, I have used the snowball method, with each respondent serving as a starting point. In the end, I have conducted in-depth interviews with 21 physicians with headscarves working in public health institutions who previously experienced the headscarf ban during education and work life. Despite its limitations, the snowball sampling enabled revealing physicians' relations and associations and representing the field's detailed information. Experiences, opinions, and expectations of the veiled physicians in public health institutions and the impact of the previous headscarf ban on their current status are uncovered through these research techniques.

Physicians have tight schedules due to intense work pressure and workload. For this reason, determining the place and time of the interview was left to the participants so that they feel comfortable and express themselves efficiently. Of the 21 interviews, I conducted 3 interviews in houses of the participants, 5 of them in private clinics of the contact persons, 1 of them is in a public institution, 2 of them in family health centers, and the rest 10 of the interviews in public hospitals in Ankara.

I have carried out the process of deciphering the recorded interviews simultaneously with the interview process. Following that, I have analyzed interview transcripts to identify the key themes. Then, I have combined the interview transcripts and field notes to constitute the core of the research and document veiled physicians' experiences in public health organizations regarding the headscarf.

Last but not least, in this thesis, I gave the participants pseudonyms. However, their ages and other personal and professional information are correct to facts. In the

analysis chapter, next to the interview quotations, the participant name, age, and spent years in the profession are given in brackets.

3.3 Field

The field of research is public health institutions due to several reasons. The health sector has a significant employment volume due to its labor-intensive character. Employment in the health sector has a fragmented structure. On the one hand, there are physicians, a highly specialized labor force that requires professional education for a long time. This type of labor force is an essential component of the sector and cannot be easily substituted. On the other hand, the health sector contains semi-skilled and non-qualified jobs, constituting a significant proportion. Thus, it can be said that the health sector is a sector where many different types of workers work together (Urhan & Etiler, 2011, p.194).

Also, medical work builds dynamic relations among health personnel. Division of labor and specialization are highest in healthcare facilities, especially in hospitals. Therefore, physicians always communicate with patients, physicians, nurses, other health personnel, and managerial staff. Patient care mostly requires teamwork. Therefore, physicians work in groups most of the time.

Plus, the medical practice requires a hierarchical relationship. Hierarchy is essential for accountability and sharing responsibility in medical care. Besides, the flow of medical information goes through this hierarchy. This hierarchy is determined according to the seniority and occupational position of medical personnel. Professors rank at the top of the medical hierarchy. Below, there are associate professors, and specialist physicians, and assistant physicians follow them. On the other hand, Allied health personnel is located at the bottom of the medical hierarchy regarding medical knowledge. However, based on their occupational position and spent years in occupation, allied health personnel might fall within different hierarchy layers. Nevertheless, the final decision of medical issues is left to physicians and the most senior.

Seniority is one of the main components of medical work. In the medical hierarchy, seniority relationship is prevalent between different professional levels and within the same professional level. For instance, assistant physicians have a seniority relationship regarding their entrance to specialty education, and specialist physicians are their seniors.

Health services are served through three sectors: the Ministry of Health, universities, and the private sector. In terms of health care facilities, healthcare services are held in hospitals, Family Health Centres (*Aile Sağlığı Merkezi*), private policlinics, and private medical centers. Besides, physicians provide health care in organizations as organizations' physicians. More than half of the hospitals are run by the Ministry of Health, followed by the private sector and universities.

According to the Health Statistics Yearbook 2018, there were 153,128 physicians (specialist, practitioner, assistant) in Turkey in 2018, and 60% of these physicians were employed in healthcare institutions under the Ministry of Health.

In Ankara, there are 16,708 physicians. In other words, 11% of the physicians in Turkey are employed in Ankara. According to Public Hospitals Statistics Report 2017, 51,496 physicians were employed in public hospitals in Turkey. Ankara has 5092 physicians employed in public hospitals, the second-highest number among all cities in Turkey. Hence, physicians in public hospitals in Ankara constitute 10% of physicians in public hospitals in the country. Among 5092 physicians, 4800 of these were specialists, whereas 292 of them were practitioner physicians. We can argue that the proportion of physicians is high, considering the population of Ankara. There were 93,5 physicians per 100 thousand people in Ankara.

Lastly, the physicians who work under the Ministry of Health are civil servants. They are paid on a salary basis based on their working years, specialization, and managerial positions. Before the annulment of the headscarf ban, veiled women could not work in public health institutions in Turkey. We can say that veiled physicians working in public health institutions are a 7-years-old phenomenon.

These aspects make the public health institutions an appropriate field to trace how veiled women become a part of the public sector employment.

3.4 Participant Profile

As previously mentioned, the respondents are veiled women physicians employed in public health institutions in Ankara. I chose the respondents according to their years of professional experience. I examined different generations to detect the impact of the previous headscarf ban on veiled physicians in public institutions today. The first group comprises physicians who had 5-10 years in the profession, with two participants with two years of professional experience. The second group had 20-30 years in medicine, with one additional participant who has spent 32 years in the profession. This kind of division revealed the impact of the exposure to ban on physicians' perspectives and understandings of their professions. I assume that the more they experience the ban, the more sensitive they are towards their profession and the relationships with the people in a complex hierarchical structure.

The average age of the participants is 38. The youngest is 26, and the eldest is 54. The variation in ages provides information on revealing how different structural challenges women face in different levels of their profession, as discussed below. For instance, during the February 28 process, 7 of the respondents worked as physicians in public hospitals; 6 of them were students; 7 did not experience the February 28. Accordingly, respondents' expectations and perceptions about their work experience in medicine with a headscarf based on their meaning and value systems differ. Nevertheless, although younger physicians did not face the headscarf ban in the workplace, they went through problems during their high school years due to their headscarves.

Table 1 ***Professional Profile of Participants***

Pseudonym	**Age**	**Years in Profession**	**Professional Position During the Ban**	**Health Institution**
Asiye	27	2 years	Student	Training and Research Hospital
Aybike	31	5-10 years	Medical Student	City Hospital
Bilge	31	5-10 years	Medical Student	Training and Research Hospital

Table 1 ***Professional Profile of Participants*** **(continued)**

Ceylan	43	20-30 years	Medical Student + Physician	City Hospital
Ceyda	26	2 years	Student	City Hospital
Derya	33	5-10 years	Medical Student + Physician	City Hospital
Dila	33	5-10 years	Medical Student	Training and Research Hospital
Erva	33	5-10 years	Medical Student + Physician	Training and Research Hospital
Esma	35	5-10 years	Medical Student	Training and Research Hospital
Fatma	39	5-10 years	Medical Student + Physician	Training and Research Hospital
Ferhan	29	5-10 years	Medical Student	State Hospital
Güzide	54	32 years	Medical Student + Physician	Training and Research Hospital
Hatice	29	5-10 years	Medical Student	City Hospital
Elif	51	20-30 years	Medical Student + Physician	Family Health Centre
Kübra	48	20-30 years	Medical Student + Physician	Family Health Centre
Ayşe	33	5-10 years	Medical Student	Training and Research Hospital
Meryem	28	5-10 years	Medical Student	Training and Research Hospital
Mine	51	20-30 years	Medical Student + Physician	Training and Research Hospital
Nevin	50	20-30 years	Medical Student + Physician	Public Institution
Nilüfer	51	20-30 years	Medical Student + Physician	Family Health Centre
Serpil	53	20-30 years	Medical Student + Physician	Private Institution

The majority of the physicians I interviewed are employed in public hospitals. Three of the physicians are working at Family Health Centres, and two participants are employed in public and private institutions as occupational physicians.

In terms of medical education, 9 of the participants graduated from Hacettepe University, four from Ankara University, four from Gazi University, one from Istanbul University, one from Marmara University, one from Uludağ University, and one from the University of Vienna. Respondents went to various high schools: private science high school, Anatolian high school, religious vocational high school, multi-program high school, regular high school, and super high school.

Regarding the professional titles, nine physicians are assistants, two physicians work as practitioner physicians, and ten are specialists. Of 10 specialist physicians, 4 are obstetrician and gynecologist; 4 are pediatricians, 2 of whom are doing subspecialty in neonatal intensive care and pediatric neurology; 1 is an infectious disease physician, and 1 is an internal disease physician. Among nine assistant physicians, three physicians receive specialty education in family practice, 1 in infectious diseases, 1 in pediatrics, 1 in otorhinolaryngology, 1 in child psychiatry, 1 in radiology, and 1 in nuclear medicine. Therefore, we can say that formerly, veiled women were concentrated in specific specialties such as pediatrics and obstetrics, and gynecology, but now it is likely to see veiled women in various specialty areas in medicine.

The average number of years in the profession of participants is 14. The most senior physician has been in professional life for 32 years, and the youngest physician spent one and a half years in the medical profession.

Almost all participants' mothers are housewives, and fathers are retired. Two of the mothers worked under the Directorate of Religious Affairs as a preacher and a teacher. Fathers had various occupations such as teacher, civil servant, engineer, executive, and the like. For married physicians, the spouses of the 8 physicians are engineers, 6 are physicians, 2 are academicians, 2 are civil servants, and 1 is a judge. In this connection, although respondents came from families with various socio-economic backgrounds, the families they founded have higher socio-economic backgrounds.

3.5 Conceptual Framework Used for The Data Analysis

As mentioned earlier, female physicians are relatively disadvantageous in the workplace due to their gender. The state of women at work has been analyzed through

the intersectionality perspective that combines gender and other inequality markers such as class, race, and ethnicity (Acker, 2012; Healy, Bradley, & Forson, 2011), religion has not been thoroughly examined. In the Turkish context, the issue of headscarf has a vital role in determining the state of veiled women at work, in addition to gender.

For this reason, Acker's (2006) theory of "inequality regimes" will mainstream my research. To examine the inequalities in work organizations, Acker introduced the idea of inequality regimes. The theory combines "intersectionality" and "workplace," which enables analysis of veiled women's participation and adaptation to public employment. An inequality regime refers to a set of intersecting practices, processes, actions, and meanings that sustain systemic inequalities based on gender, class, and race. Acker defines inequality in organizations as:

> systematic disparities between participants in power and control over goals, resources, and outcomes; workplace decisions such as how to organize work; opportunities for promotion and interesting work; security in employment and benefits; pay and other monetary rewards; respect; and pleasures in work and work relations (p. 443).

The political, historical, and cultural background of society impacts this inequality as well. In this connection, I suggest that the headscarf should be conceptualized as a distinct dimension of inequality regimes operating within organizations in the Turkish public sector.

It should be noted that although all organizations have inequality regimes (Acker, 2006), public institutions have a more equitable, open, and diverse work environment and do not legitimize inequalities. Therefore, one could expect not to see any kind of discrimination or exclusion of veiled women in the labor force after the annulment of the headscarf ban in public institutions. Nevertheless, the repercussions of the ban implicitly float around. In such circumstances, Acker (2006) uses the term "visibility of inequality" and defines it as “the degree of awareness of inequalities” (p.452). Inequalities might be invisible, denied, or avoided in the workplace. People in dominant groups mostly do not recognize inequalities. In other words, inequalities in the workplace are visible to those who are exposed to inequalities. Veiled women who experienced the headscarf ban and the women who did not witness any headscarf-related problem are different. For instance, veiled physicians who suffered from the

ban are more sensitive to discrimination based on the headscarf. However, veiled physicians who did not experience the headscarf ban do not consider the problems they face in the workplace as related to the headscarf.

The legitimacy of these inequalities is another issue to be discussed. In organizations with democratic and cooperative nature, inequalities are not welcomed (Acker, 2006, p.452). However, in organizations with rigid bureaucracies, inequalities are legitimized. Since medical work depends on the hierarchy based on medical knowledge, inequalities based on gender, race, class, and the like are legitimate. The attitudes of superiors in the hierarchy could not be questioned, and therefore, inequalities float around legitimately in the medical workplace.

Similarly, another term of Acker (2006), "organizational control," is achieved through the hierarchies. This control could be legal but contains hierarchical organizational power. It can be either externalized or internalized. Externalized or direct control includes bureaucratic rules and regulations, rewards, wages, coercion, and violence. However, internalized control has a complex nature. It includes “belief in the legitimacy of bureaucratic structures and rules as well as belief in the legitimacy of male and white privilege" (p.454). In other words, organizing relations and the inequalities within are internalized and perceived as normal. They could be "taken for granted as the way things naturally and normally are" (p.454). The discriminations female physicians face stem from this kind of administrative control in the workplace.

Acker (2006) identifies the steepness of hierarchy as one of the variables that affect the shape and degree of inequality. According to her, an inequality regime is more probable in workplaces with a hierarchical structure (p.445). Higher ranks of the hierarchy are mostly occupied by white males, which shows the inequality based on gender and race. On the other hand, equality is achievable in workplaces with team structures in which people share the responsibility and decision-making authority. However, considering the structure of work in medical institutions, one sees that it contains both hierarchy and teamwork. This complicates relations in the medical profession.

According to Acker (2006), informal interactions while doing the work produce inequalities in the workplace. People in the workplace produce appropriate

assumptions based on gender and race and exhibit appropriate behaviors accordingly. "The situation, the organizational culture and history, and the standpoints of the people judging appropriateness" are the main determinants of what and who is appropriate at the workplace (p.451). Overlooking women and people in color, not including them in social gatherings, and the like are examples of this type of inequality. In terms of veiled physicians, veiled physicians' neglection and social exclusion by their professors during training in hospitals might be counted as inequality based on informal interactions. Also, since veiled physicians limited their time spent on university campuses, they did not attend non-compulsory classes or social or scientific activities that students' clubs organized. This limited female medical students' informal interactions with professors or colleagues and resulted in a lack of medical information gathered through these interactions for veiled female physicians.

Besides, veiled women face mobbing at the workplace for several reasons. As mentioned before, the hierarchy at medical institutions is based on seniority and medical knowledge. Veiled physicians' access to medical information was hindered through actions such as not giving clinical cases to them, or ignoring them and their questions during training sessions, or rejecting their participation in surgical operations because of their attire. In some hospitals in Ankara, veiled physicians resigned due to such mobbing implicitly targeting their headscarves.

Additionally, the type of organizing process also produces inequality. Notably, "organizing the general requirements of work" causes and reproduces gender-based inequality. "In general, work is organized on the image of a white man who is dedicated to the work and who has no responsibilities for children or family demands other than earning a living" (Acker, 2006, p.448). Since women have more responsibilities at home, they mainly prefer jobs that enable family-work balance. Otherwise, they have difficulty in maintaining the balance of work and family lives.

Besides, in team works, female physicians have relatively lower voices compared to their male colleagues. Berger, Cohen, and Zelditch (1972) explain why social hierarchies emerge in small, task-oriented groups with a theory. According to status characterization theory, both known information and implicit assumptions based on specific characteristics lead to a person developing an assessment of another's ability,

skill, and value. In other words, the hierarchy within the group is mostly influenced by the effect of social cues that are often guided by stereotypes of race, gender, age, class, and looks on the assumptions. The status brought specific evaluations and expectations of performance for group members, and the distribution of participation, influence, and prestige among members of groups is determined accordingly. Being a female physician with a headscarf, in this case, may push women physicians to the lower levels of social hierarchies in the workplace. One objective of this study is to question the headscarf's role in this hierarchical system, if any.

3.6 Advantages and Limitations of the Study

The interview started with demographic questions and progressed from general to specific. However, the interview framework could not be applied in the same order of questions for each participant. Therefore, the order of the questions changed sometimes, and this provided flexibility to the interview. Some questions were not asked, or new questions were added according to the flow of the story.

As stated earlier, due to physicians' tight schedule, the place and the interview time were set by the participants, and there is no doubt that it was not very easy. Participants set the interviews between their patient appointments, or during their night or weekend duties, or end of the shifts, or even during their maternity leaves. Therefore, keeping up with physicians was a difficult task.

Due to their tight schedule, I started interviews after a short briefing about the study. Hence, no rapport was built beforehand. However, after the interviews, almost all the respondents were pleasant and behaved warmly and stated that this study reminded them of the struggles they faced earlier due to the headscarf ban and drew their attention to recent experiences with the headscarf in the workplace. While saying goodbye, the respondents expressed good wishes and thanks, stated that they were happy to have contributed to such a study, and invited me for a coffee whenever I am free.

Some participants were willing to help me with my thesis since they were writing their theses in the meantime. On the other hand, some agreed to meet me because they love or respect our contact person.

However, most of the respondents agreed to do the interviews because the research topic meant a lot to them. During two of the interviews, the participants felt emotional and started to cry, whereas they remembered when they suffered in medical education and the workplace because of the headscarf ban. Although I wanted to end the interview, they insisted on continuing. At the end of the interviews, they thanked me for being a part of such a study.

Participant observation is impractical in this study due to the nature of the medical profession. Because of the physicians-patient confidentiality and the privacy of physicians' relations with each other, participant observation would not help to assess the relationship between physicians and patients and the potential impact of the headscarf on this relationship, if any. Therefore, although participant observation was tried several times, only an in-depth interview was used as a data-gathering tool in this study.

In addition, qualitative research does not aim to reach absolute conclusions. Instead, it points out how generalizations could be made through the findings (Cindoğlu, 2010). In this regard, this study's findings do not generalize the experiences of physicians with headscarves regarding their participation in public employment. However, it indicates physicians' experiences with headscarves on the headscarf ban, its psychological reflections, and its repercussions on professional life.

Since the labor force and employment data do not categorize women as veiled or not, qualitative research was not possible for this study to track the change in the number of women in public employment after the abolishment of the headscarf ban.

CHAPTER 4

ANALYSIS

To analyze the research findings, I determined some key themes. These key themes provided a framework in which one could efficiently trace the experiences of veiled physicians in their education and work-life during the headscarf ban and the reflections of this ban on their current professional lives as well as their perceptions about the abolition of the headscarf ban, and finally their process of adaptation to the public health sector. The key themes that are examined respectively are deciding to become a physician, headscarf narratives and experiences during the headscarf ban, psychological effects of the headscarf ban on student and professional lives of the participants, assessments upon the abolition of the headscarf ban, being a veiled physician in the public health sector, and being a female physician in the public health sector.

4.1 Deciding to Become a Physician

In terms of choosing a profession, most of the participants decided to become a physician during their childhood. While some participants made their decision during high school, other participants chose to become physicians during the university preference period, based on their University Entrance Exam score. Also, one participant dropped out of the engineering faculty and decided to become a physician.

In other respects, the reasons behind this preference are various. While some participants became physicians because their families desired so, others chose the medical profession for its prestige and advantages. Another common motivation

behind choosing to work as a physician is helping people and receiving their prayers and good wills:

> Because I love studying Biology. People show gratitude and send their best wishes and prayers to physicians. It is a high-status job. It's also because if you get high scores, you go to medical school or you go to law school, that is the expectation. Along with these, I love communicating with people and want to be a successful modal person, and being a physician was ideal for these objectives. (Meryem, 28, 4)

> But I love helping people. I think it is an irreplaceable profession. You can replace someone for any other job, train them a little, and you are good to go. However, to replace a physician, you have to have at least six years of training as a practitioner, ten years if he is a specialist, 15 to 20 years if he is an associate professor. (Hatice, 29, 5)

While studying engineering, Aybike decided to become a physician. The main reason is her idea that she could fulfill her religious duties in the medical profession, not in engineering:

> I thought that I would not be able to fulfill my religious obligations properly in engineering. I will spend my life there working daily from 6 am to evening, but what will they give me other than money? I thought I could not get spiritual satisfaction in engineering. (Aybike, 31, 6)

Interestingly, Derya decided to become a physician as she could enter the exam with her wig and hoodie. Although she took her headscarf off, she put on a wig and felt secured with her wig and hoodie on top. Since no one told her to take her hoodie off, she relieved and did her best score in the exam:

> Since I was going to put on a wig for the first time, I was anxious. I put on my wig and then swept my hoodie on top. Hoodie makes me feel safe. I kept my hoodie on in the exam place and waited around 5 to 10 minutes for someone to warn me, tell me to remove it. Nobody came, and I figured they forgot about it. I started my exam very excited and happy because nobody told me to remove my head cover, and I did my best score until that point in my life. (Derya, 33, 10)

However, it is worth mentioning that participants who spent up to 30 years in the profession have different reasons for choosing medicine than participants who only spent up to 10 years in the profession. While formerly veiled women preferred medicine to serve society and thus worship, newcomers do not mainly put religious values to the center while choosing a profession. Also, the residency preferences of these two groups differ significantly. Older women in the profession mostly preferred residencies known for their suitability for women: pediatrics, obstetrics, and gynecology. However, veiled women who entered the medical profession maximum

of 10 years ago have different motivations in choosing residencies, such as TUS score and medical residencies' features and requirements. This group of women works in a wide range of residencies such as nuclear medicine, radiology, psychiatry, and otorhinolaryngology, in addition to traditional ones.

Ceylan's case is noteworthy since her family said they could only let her study if she goes to medical school. This, in a sense, shows the mentality of conservative families who did not support their daughters to receive education, and if they did so, they only allow teaching and the medical profession, which are the two main jobs suitable for women. In her own words:

> When I was a child, my family always said "You can only go to university if you study medicine". I am the first woman in our family who received higher education. (Ceylan, 43, 19)

Among 17 participants who answered the relevant question, 14 were encouraged by their family while selecting the medical profession. While a great majority of participants made their decisions on their own and were highly supported by their families, few participants did not think of any other profession since they were raised with the insistent suggestions of their parents, like "you are going to be a physician one day". On the other hand, 3 respondents did not get any support from their families regarding their professional preference. Of 15 participants who responded to the relevant question, 5 physicians do not have any other physician in their families. The other 10 have physician relatives such as husband, sibling, children, cousin, and the like.

When I asked how they selected their residency in medicine, I received several answers. Among the reasons for choosing their residency, 6 participants stated that they made their decisions based on the features and requirements of medical specialties such as patient profile, workload, required skills, and the like. Following that, 5 participants chose their residency according to their TUS score. However, the headscarf became grounds for choosing their residencies of 4 participants. Mine explains this as follows:

> One of the reasons I chose neurology as my subspecialty is that if the headscarf ban is reinstalled and I lost my job in the public healthcare institutions, I still could perform my profession in my private clinic. "Just in case," said my neurology professor,

> "choose neurology, so that even if the ban is reinstalled, you can still perform". Our anxiety continues. It (the ban) still is right behind us; I feel that way. (Mine, 51, 29)

Among 17 participants who responded to the relevant question, 12 are pleased with their profession and residency. However, 5 participants dissatisfy with their profession due to numerous reasons such as the difficulty of working conditions, health policies, violence against medical personnel, lack of material and spiritual satisfaction, and the discrepancy between the efforts and their outcomes.

To conclude the medical profession section of the interview, I directed the question of "what qualifications should be possessed to be a successful physician" to participants. Good communication was mentioned by 9 participants, and it was followed by empathy with 8 participants. Keeping oneself up to date with the latest developments in medicine by reading a lot and being enthusiastic, willing, and loving the profession were mentioned by 5 participants as features of a successful physician.

4.2 Headscarf Narrative and Experiences During the Headscarf Ban

The greater part of the participants decided to wear the headscarf during medical education in university: 9 of the participants wore the headscarf during university, 7 of them during secondary education, 3 of them during high school, and 2 participants decided to wear the headscarf when they started working as a physician. All participants decided to wear the headscarf on their own. Many of the participants unveiled at school due to the headscarf ban:

> I donned the headscarf in my first year at university when I was 19. It was a spontaneous decision, not pre-planned. I was going to go to my first committee exam, suddenly, I put the headscarf on and went out like that. Although I was a religious person otherwise, I just did not use to cover my hair. That day, I wore the headscarf, went to school, took my headscarf off, and took the exam. (Dila, 33, 7)

The timing of wearing the headscarf, however, was determined according to the headscarf ban. The ban caused delays on decisions to be veiled for some participants:

> I made my decision to cover up in high school, but I could not follow it. Headscarf ban was still in place those days, we could not even get in the schoolyard, we had to take it off outside. My hometown is already a small town. So, I had to leave the house with the headscarf, walk a little bit, and then take it off… I gave up. (Esma, 35, 7)

> I decided to veil in the second grade of high school, but I could not do it due to pressure from my family. They prioritized graduation from school first. I wore the headscarf fifteen days after graduation. (Nevin, 50, 27)

The strategies of the participants adopted in the face of the headscarf ban during education and work-life are various. While some physicians took their headscarves off, some wore bones in the workplace, and others put a wig on their headscarves. Some participants sought other solutions abroad. Some physicians insisted on working with the headscarf and therefore were exiled to peripheral health institutions where they could work invisibly yet still with the possibility of interrogation and discharge. Other women did not abandon the headscarf and dropped out of school or quit work, but they are not the subjects of this thesis. Also, most of the women took the headscarf off to complete their education. These women used different strategies in their work lives.

To minimize their exposure to the headscarf ban, a substantial part of the participants attended private science high schools for girls where they might be relatively comfortable:

> On the high school entrance exam, I got a score that I can be admitted to the most elite high schools in Ankara, however, I did not apply to any of them. We specifically looked for a school that had a more relaxed approach concerning the headscarf ban. Although we took the headscarves off, we could put on hooded tops at that time. That is why I chose that high school. (Bilge, 31, 4)

Following that, veiled women continued to make their university choices according to the headscarf ban:

> Even little things at Gazi Medicine, such as removing our headscarves inside the school building instead of removing them at the campus gates, were relieving. This was a motivating factor in my preference to apply to Gazi Medicine to study, even though I could get into higher-ranking schools like Ankara Medicine or Çapa Medicine. Removing your headscarf at campus gates was all about humiliating women. I would feel humiliated if I had to experience it. (Aybike, 31, 6)

> After the residency exam, I had to choose institutions where I could wear my headscarf. Since those institutions are rare, it created an extra competition among veiled women besides the general competition of the residency exam. Van University was a newly established university with fewer academic staff and no technical field of study, whose dean of Medicine, we know was a fatherly figure that all our friends respected. Nobody other than veiled women wanted to go to Van because of the turmoil caused by terrorist attacks in the region. But it was an environment where we were wonderfully comfortable with the headscarf. That is why we chose Van, despite all of its downsides. (Mine, 51, 29)

One participant went abroad to receive medical education after she was refused by Yeditepe University, where she applied because she was told that she could wear the headscarf while studying there. Yet, she lost three years total during her struggle:

> When I was not accepted to Yeditepe University with my headscarf, I studied to learn English for a year, to seek an opportunity to continue my education abroad. Then we went to Austria, we had to learn the German language for another year. After graduating, degree equivalency certificate procedures took an average of one year for all of us. In total, 3 years of my life were wasted for such nuisances, where I could be practicing medicine instead. (Fatma, 39, 7)

Participants who did their compulsory services in the periphery, i.e., rural parts of Anatolia, observed a less strict implementation of the headscarf ban. Rural people had little or no negative view of the headscarf, as well as the institutions, and this, according to participants, had a positive impact on their work:

> I was appointed to Nevşehir after graduating and I worked in maternal and child health. I did not have a problem there, probably for it is a small city. (Nilüfer, 51, 29)

> I worked in Şırnak for 6 months as a compulsory service, in the maternal and child health family planning department and I was the only physician there. They provided convenience and I worked with the headscarf. I think it is because of the management: there was not much inspection process, and whenever it happened, they turned a blind eye to my headscarf. I was the primary responsible physician there. The patients were not opposed to it at all. (Erva, 33, 10)

> I was amazingly comfortable in Çorum. I did not have a problem while working there. For local people, there was even a tendency towards getting an appointment from a veiled physician. I was also the only female physician. While everyone was doing 30-40 appointments per day, I was doing 170-180 appointments per day. (Mine, 51, 29)

However, the veiled physicians who did not abandon the headscarf while working in the public health institutions in urban areas were requested to remain invisible. To render them invisible, some of them were sent to peripheral, relatively less populated health institutions where they would not catch an eye. In this respect, the approach of the public sector resembles the private sector. For instance, many private companies put veiled women in positions in which they are in no contact with the public, and thus, they could be invisible (Jelen, 2011). In participants' own words, veiled physicians were expelled to remote places in conservative neighborhoods with low socioeconomic levels, where the probability of getting a complaint about the veiled women would be lower. Participants thought that they probably would not be able to attain peace in the workplace if they were put under the spotlight.

Yet, official interrogation and probable discharge from the profession were still a high risk for physicians working with headscarves during the ban. For instance, during the ban, Kübra worked with her headscarf in a health center in a remote district of Ankara. She had numerous investigations and penalties that resulted in a suspension from the profession. When she filed a suit to return to her job, the court decided to reinstate her however, to a health center in the periphery.

This abovementioned group of women had twenty to thirty years in the profession and were exposed to sanctions towards women with headscarves during the February 28 period. For instance, Güzide had to take a medical leave of absence report for a couple of months and try to think it through and decide. Afterward, she decided to push forward as far as she could with the headscarf:

> In the end, we decided to continue for as long as we could. I continued working with my headscarf and got in a lot of trouble for it. They would write us up and give us slips. By this time there were no other veiled people in the hospital. Since there were only a handful of us left, they probably didn't want to make such a big deal, but they didn't allow us into the hospital. I was placed at the district polyclinic because I had a headscarf, they didn't allow me into the main building. I worked there for a long time, 11-12 years. (Güzide, 54, 32)

Even after the Justice and Development Party came to power, hospital management could not decide what to do with veiled physicians. The solution was again making them invisible at work:

> They couldn't figure out what to do with us. The polyclinic was on the top floor. Because I refused to take my headscarf of or wear a bonnet, they brought it downstairs. The top floor became the bird flu service, the only bird flu unit in Ankara. There was always press around so they kept me away so they would not see me. They did help, however. Once I was clear that I would not take my headscarf off, nor wear a bonnet, they were helpful. They brought the polyclinic here. Our service was here too so when they brought it over it was better for us. They allowed us to become invisible. We didn't use the physician's rooms; the specialists had an area where they would hang out, we never went there either. We made ourselves invisible. (Güzide, 54, 32)

Not all women were that lucky. Therefore, the physicians in higher, more prominent positions renounced their positions for the sake of keeping their headscarf. Serpil, the deputy chief physician in Samsun, resigned from her position after she was not allowed to cover her head:

> The chief physician didn't allow me to wear my headscarf because I was the deputy chief physician. I quit then and switched to working as a primary care physician so I could work while wearing my headscarf. (Serpil, 53, 30)

Also, the professional life of Güzide has been reshaped by the headscarf ban. While working in a university in Trabzon, she gave up her academic career when she found out that she could work with her headscarf in a small-scale polyclinic in Ankara instead:

> After completing my residency, I was going to return to Trabzon but had to first set up my compulsory service. I started as a temp at the district polyclinic over at Numune. In theory, I was going to go back to Trabzon, but no one interfered with me working with a headscarf at the small-scale district polyclinic. Since that was the case, I didn't want to have to take off my headscarf and return to Trabzon as an assistant professor. I liked working with my headscarf. That's why I left Trabzon and started working here. (Güzide, 54, 32)

Women with headscarves "have often had to work in jobs outside and below their informational, educational and professional equipment, accepting much lower wages than other employees in the same position" (Özipek, 2008; p.16). In other words, veiled women were overexploited, as they had limited options for the job market.

In the physicians' case, the women who wanted to continue working with the headscarf applied for a job in private hospitals owned by conservative circles. Barbarosoğlu (2010) stated that by offering low wages, the capitalist system claims that a veiled woman's labor is worth less than the labor of an unveiled woman. Moreover, even this unjust low wage was regarded as a donation since employing a veiled woman is considered as taking a risk. Along with that, the extend of overexploitation in private hospitals reached an extreme level. For this reason, private hospitals became the last option of veiled physicians:

> In the private sector, women with headscarves were only employed for night shifts and paid 15-20 TL per day, far less than what they paid the men. The private sector would only allow you to work nights and not days out of fear. Working at night back-to-back every day is impossible; how many shifts could you do in a month? (Nevin, 50, 27)

Another option for women physicians was opening their private clinics to work. Nevertheless, for a new graduate without an established customer base, founding a new private clinic is a high-risk venture and often deemed to fail. Mine, who was discharged after she attended a public protest demanding freedom for wearing a headscarf called "Hand in Hand for Freedom", could return to the public sector only after the annulment of the ban, worked in her private clinic for 16 years in the meantime:

> Physicians in public hospitals would do checkups for 50TL, I would do it for 40 TL. Say you're about to make a deal with a private hospital, if I didn't have a headscarf, they would agree on a 10 TL rate but because I wore a headscarf, they paid 6-7 TL. A system of exploitation was born. Since you wore a headscarf, you couldn't get a job in public hospitals, so they made you work for less. I don't want to go back to the private sector. I don't want to work at a private check-up center ever again. I'm coming up from behind in every sense. For example, normally my peer would be a senior professor of 7 years. I still have 3 years until I become one. (Mine, 51, 29)

Although women could complete their medical education, their career path was determined according to the ban. Nilüfer became a practitioner physician just because of the ban:

> I did not choose my residency because I couldn't enter the TUS with my headscarf. I didn't have an option to go somewhere other than Ankara because my husband was here. I had to take out residency out of my life completely. (Nilüfer, 51, 29)

One of the participants could not receive her diploma from her school after graduation and left with a temporary graduation certificate. First, she was not allowed to do the registration cancellation procedure. After the officer argued with another student for some reason, he showed mercy and gave Kübra's temporary graduate certificate:

> Otherwise, they wouldn't give it to anyone. It's a situation where you've finished school but can't receive your diploma. We received our diplomas 20 years later. (Kübra, 48, 20)

The participants' narratives particularly highlight medical professors' attitudes during and even after the abolition of the headscarf ban. During the ban, various types of mobbing occurred. Students with headscarves were expelled from classes, humiliated, and harassed. Students who wore a wig faced the same situation as well:

> You're in small groups of five where the professor goes around asking everyone their name and where they are from but skips you when it's your turn. They would give a 3-hour long class without once asking your name. Why? Because they don't see you as a [person]. You might as well become buddies with the professor. You're there right next to them as they joke around. There was this constant mobbing. You get on the elevator with a professor and an associate professor, everyone else gets off and you're still together for 2 more levels. He says things like "you look like a penguin, your headscarf is horrible, do you not look at yourself in the mirror" for the rest of the ride. All the time. Or in class they say "You are all the creme de la crem of Turkey, you are in the top 1 percent of youth. And then there are these women. What can we do?" (Derya, 33, 10)

> One of my professors cornered me in front of everyone. She walked up straight to my face wagging her finger saying "I'm a very influential profess" threatening me. I remember it very well. (Bilge, 31, 4)

In cases like these, veiled physicians mainly remained silent not to exacerbate the situation. Interestingly, women who experienced the ban severely refrain from raising their voices. However, the new generation who did not witness or experience the headscarf ban is more assertive at claiming their rights, as will be discussed later.

4.3 Psychological Effects of the Headscarf Ban on Student and Professional Lives of Participants

One salient thread in the participants' narratives is their hard work to be acknowledged in education and work life. Covered physicians adopted hard work as a strategy to overcome the negative effects of the headscarf, even after the abolition of the ban. Ceylan's case is significant in terms of showing the efforts of covered physicians to balance the discrimination the headscarf causes by working hard. She took her headscarf off while working until the abolition of the ban and did not experience any serious problems. She explains why:

> Even though I took my headscarf off when studying or working during the ban, I would still hide from others. I tried to stay invisible as much as I could. I never experienced direct discrimination. In university, getting kicked out of class was one type of discrimination in itself. But I didn't experience anything like that while working. But that was because, since I already started one step behind, I would work even harder to make up for it and not stand out. You work harder. The headscarf would bring you a step back so in order to make up for it you would work even harder to break even. That's why I didn't experience that much mobbing due do my headscarf. I didn't experience that while working either and I think its because of what I did. If I were to make a mistake, work like everyone else I could be criticized. Perhaps even punished more than the others. But I worked hard enough to never give them the chance. (Ceylan, 43, 19)

Besides, working hard is a strategy for covered physicians of all ages. Both participants who are relatively new at work and have spent twenty-five years in the profession used this strategy to be noticed and to keep themselves from discrimination based on the headscarf. However, they all experienced the headscarf ban to some extent in their educational or work lives.

> I was a successful student at university. I've always been hardworking, and this continued during university. But I realized for the first time in Ankara medical, that to be on the same level as my peers in my professors' eyes, I had to work twice as hard as everyone else because of my headscarf. If someone was giving x amount of effort,

> I had to give 3x amount of effort for the professor to see me or recognize my hard work. That's why I felt like I always started down 0-3. It's like there is a glass in front of them. First you need to break the glass, or a curtain; you need to make a move to pull back that curtain so that they can see you as a student. (Meryem, 28, 4)

> As I say, a covered physician should work harder at work. If everybody works 1, you must work 5. There is no tolerance for them to make mistakes. (Mine, 51, 29)

While mentioning what the headscarf means to them, participants stated that the headscarf serves as a protector, making them self-assured. It is something that integrates with their whole being, personality, and something that completes them. Having their headscarf and dream profession on opposite sides made physicians stuck in the middle and frustrated. Most participants expressed their feelings about the ban and how it made them feel during education and work life. They mostly felt discouraged, aggrieved, and frustrated. Participants even had an identity crisis since they regularly put their headscarves on and took them off. This, in the long run, affected their attachment to their profession negatively:

> People would think that we were forced into it. I'm a person with a brain and the intelligence to get into medicine. Who, after that age, could be forced to do anything. I want to do it. Yet I come into this disgusting ridiculous bathroom take it off and put it on. This is a bother, it slows you down in the first place. (Esma, 35, 7)

> It's difficult to be yourself, to establish your personality, to say that you're here. You're already students, so if the professors' knowledge is there, you're here. At the same time, you're subject to constant social oppression. It ends up being a process where you're just like "what is this? What am I dealing with? I'm just going to drop out". (Derya, 33, 10)

> Two different personalities, two different identities. It's like splitting your identity into two. That's how I remember that time. You belong neither there nor elsewhere. I couldn't embrace it. That was something significant for me. (Dila, 33, 7)

> I don't think we were living our actual realities. It brings something like a split reality. You don't have a headscarf on at school, but you have one on outside. It's like you're split in two. You're still the same person with the same ideals but because you have the headscarf on sometimes and off others – it affects you. It affects your spirituality. And I think this split leads to a lot of internal conflicts for someone. What am I? What am I doing? It's the most ridiculous thing in the world. I don't know if I could explain it but it creates a wound in your soul. The fact that you can't put yourself forward, act as yourself, act as how you really want. (Aybike, 31, 6)

On the other hand, the ban made some participants stronger, contributed to their identity in a good way. Derya explains how the ban helped her to find herself:

> It gave me a militant identity at the age of 13 because my family, despite me wearing the headscarf, wanted me to take it off. … In the long run it's been process that I'm

> happy I lived through. Because even though some things were awarded later on, and even though the ban was lifted, it allowed me to view my headscarf with a seriousness for the rest of my life. I became aware that it was something that was fought for. So, it prevents me from ever underestimating the importance of my headscarf in my current life, it gives me a firm stance. Something that back then was seen as a great disadvantage, now provides me with a different level Islamic spirituality, making me appreciate it more. (Derya, 33, 10)

The medical profession involves lifelong learning. In the medical profession, a physician is in a student position in his entire work life. Following up the academic literature, reading recent articles on the field, keeping up with the newfound treatments and the like are required for a physician to do his job properly. As mentioned earlier, during an internship, assistantship, and doing subspecialty, physicians are trained in hospitals by professors. Their education life and work-life intermingle in a sense. In this respect, discrimination during education negatively affected the work-life of a physician. Although women's experiences during the headscarf ban itself were not the main research interest of this thesis, it is important to mention it due to the strong link between medical education and the medical profession. For instance, Ayşe felt discouraged as she felt she lagged behind her real potential, both socially and academically:

> I really wanted to go to medical school. Although I was very enthusiastic, because I didn't have my headscarf on, I did not feel like I was myself so I wouldn't attend any activities other than classes. I couldn't quite express myself and I think this had an effect on my success. I think I could've been more active and academically higher and more successful. I believe there was something missing. Because I was not there as Ayse, but as whoever they wanted me to be. I always felt bad during the time I went to school without my headscarf. The inability to express myself back then I think decreased my potential. And of course, it affected my present. After spending six years like that, you can't just re-energize yourself and get going. (Ayşe, 33, 7)

Since they cannot be themselves in that kind of appearance, covered students could not fully involve in medical education. Consequently, their belongingness to their profession was limited. Bilge, who was not accepted even as an audience to her "white coat ceremony", a traditional entrance ceremony to medical education, could not make peace with medical education and school afterward:

> Attendance wasn't mandatory in our classes anyway, I made it to a few classes in the first three years. I only went to mandatory classes and exams. After seeing that it wasn't working, I dropped out in the first year. But then my family disagreed, and I continued. I didn't attend classes anyway, so I just waited it out. Honestly, I stopped taking school seriously after that. Because it was no longer an environment I embraced, I didn't want it, I didn't like it. The classes were hard anyway so it's not

> like you could wing it you had to study. There was a time when I wanted to communicate with the professors one-on-one. When I entered the class with a wig, the professors were not answering my questions. For example, I asked a question to the professor, he pretended as if he never heard me. (Bilge, 31, 4)

The headscarf ban affected the education life of physicians both directly and indirectly. Due to the ban, female students could not get used to their medical schools. They minimized their presence at school to avoid the ban. For instance, they only attended compulsory classes, did not join student clubs, or did not study in the library. Therefore, medical students with headscarf could not be engaged fully in academic life and thus felt alienated:

> I didn't go to non-compulsory classes that didn't have mandatory attendance. I used to like working at the library, it was comfortable, but then they put a ban there too, so I stopped. I tried to avoid conflict as much as I could. (Dila, 33, 7)

> Since you cannot wear a headscarf at school, I could not attend any club. It was something I was deeply sorry for. (Meryem, 28, 4)

Besides, the limited participation of veiled women in education and work lives resulted in less informal interactions. Acker (2006, p.451) argues that people in the workplace make assumptions on people's appropriateness based on gender and race, and consequently, exclude those labeled as inappropriate. In our case, by not attending classes or students' clubs, veiled women limited their informal interactions with professors or colleagues. This resulted in a lack of medical information gathered through these interactions for veiled female physicians and debarred these women from the advantages of informal interactions.

Despite all the hardship, veiled physicians who spent more than 20 years in the profession and experienced the February 28 process continue working for several reasons. First, since the medical profession is prominent and requires great effort, giving it up is not quite an easy thing to do. Second, the situation of the patients made veiled physicians continue to serve and treat the patients. For instance, Nevin decided to continue her profession after the February 28:

> Of course, it was not just the workers that suffered, people who came for an appointment with a headscarf on would also be discriminated against. A lot of our patients would say "they started treating us like humans after you came, before you they wouldn't even accept us into their rooms…". When I was there someone in the room across mine once yelled "Don't come to me there is an Iranian across there". The Iranian is me because I wore a headscarf. Patients had to hear stuff like "Go have her give you your check up, why are you living in Turkey, go live in Iran". I'll never

> forget one of my patients said “they attempted to pull out a healthy tooth, please don’t leave us in their hands”. Then I made a decision, even though the headscarf ban continued we made a decision. To wear wigs on top of the headscarf. (Nevin, 50, 27)

4.4 Assessments upon the Abolition of the Headscarf Ban

When asked about their views on the abolition of the headscarf ban, participants stated that it was the ban that separates people. Putting on and taking off the headscarf caused trouble. Now, everything is clear, thus normalized:

> But that other section of society started to normalize after the ban was lifted. They started to accept this situation as normal. For a long time, I do not think that I have been marginalized because of my headscarf. It has had positive aspects in this process and in changing people's perspectives. (Erva, 33, 10)

> We have seen that we can communicate and understand each other and get along as a society. Later, I thought that there was no problem with us. The problem was between other people. I did not experience any personal difficulties in general after the ban was lifted. (Ayşe, 33, 7)

> I work with a headscarf, and people do not find it odd. Formerly they see me unveiled at school and veiled outside; there was a strange situation, "Oh, she is veiled." they say. Their attitude also changes. Now I am comfortable. They always see me that way. I do not feel anything like: this person mistreats me because I am veiled. There was no problem. I did not even think even once, "I wonder if they made this move just because I am like this.” They made unnecessary prohibitions, strange moves. (Esma, 35, 7)

In a similar vein, Asiye claims that the headscarf ban grouped people based on their headscarf perceptions and put them apart. With the abolition of the ban, social relations ameliorated, and conversations are easy now:

> You always seem like a separate class in society. However, when you go to university with your headscarf, you are accepted much more quickly the way you are. I think it is much better in friendships. I had many friends from all walks of life, and nobody found me odd that way. Because I went to college as who I really am. If there is no ban, you continue to be as you are in school or the public. Nobody estranges you because that was not a strange thing in the first place. It was an anomaly that it was banned. (Asiye, 27, 2)

Some participants stated that they could not believe it when they heard that the headscarf ban was lifted. Although veiled women could not get used to and accept the headscarf ban, they had no hope about its abolition:

> If they had told me 25 years ago that something like this would happen, even if I had seen it clearly in my dreams, I would not have believed it could happen. It feels very unreal. (Nilüfer, 51, 29)

> I could not believe that the ban was lifted. I thought it would not happen. I said it is not possible because I have long-term trauma. (Derya, 33, 10)

Nevertheless, veiled physicians, especially those who experienced the February 28 process, could not fully overcome the ban's trauma. They still feel like they might be exposed to discrimination based on the headscarf:

> Even when we go to public hospitals, we see working staff with a headscarf. It makes us happy; it surprises us a lot. But I still feel that old times pressure. We feel that way, even if we do not know what the other person is thinking, because of the things we experienced formerly. (Elif, 51, 27)

Physicians with headscarves also pointed out how pleased, relieved, and content they are with the abolition of the headscarf ban. For instance, Nevin stated that they have no workplace problem anymore except common problems in Turkey like everyone else does. While some participants attributed this relief to society's readiness to embrace women with headscarves, other participants stated that they did not have difficulty in their workplace because they picked their place of work accordingly in the beginning. Based on their university experiences, participants generally avoided university hospitals for subspecialty and chose mainly training and research hospitals, where they assumed that they would encounter less discrimination. Among others, Bilge did not face any discrimination, and she attributed it to her preference of hospital:

> I have never encountered a problem related to the headscarf. And thankfully, since I have been wearing a headscarf, I have not been found odd, except the medical congresses I attended. In my current workplace, most of our professors are believers, some of them wearing headscarves. I see such an environment for the first time. I thought the environment was good, that I could feel good about myself. I am in a place where I am happy. (Bilge, 31, 4)

However, many things have changed since then, both in a good and bad way. Most physicians with more than 20 years of work experience stated that the headscarf's meaning had changed now. Accordingly, Muslim women and society at large have changed. From time to time, as they argued, participants miss the times of the ban:

> I think the headscarf lost its value when the ban is lifted. It is not just because the ban has been lifted; society has already changed. Veiled women, Muslims, religious understandings have altered. I think we lost our values, especially the headscarf in university years has no value now. When it was liberated, its value diminished. (Ceylan, 43, 19)

> Yes, people are more comfortable, but I think we lost our Islamic identity with liberation. There is a hijab fashion. People's high esteem of wearing a headscarf has decreased. I expressed my Islamic identity more easily when there was a ban. (Mine, 51, 29)

> I was much more careful during the ban. I felt closer to Allah. The more we let go of everything, the less we started to think. It was a good thing to have those valuable attributes at that time. (Elif, 51, 27)

> Before, you struggled for an Islamic identity. Now it is easy to wear a headscarf for women whose mothers and fathers are Muslim people, in Muslim circles, and so on. (Güzide, 54, 32)

> There was pressure on people with headscarves, and people were closer to Allah's approval. When this pressure was removed, many things have changed. I see veiled people who have become too liberal and moved away from Allah. (Nevin, 50, 27)

In a similar vein, one argument that came to the fore in the interviews is the difference between the women who experienced the headscarf ban and women who were not exposed to the ban. These two groups have different attitudes and behaviors in life. While the former is more sensitive and prone to perceive discrimination and mobbing based on the headscarf, the latter does not consider the headscarf as a matter of discrimination. This finding could be assessed through the concept of "visibility of inequality" of Acker (2006, p.452). According to this concept, people's awareness of inequalities plays a key role in the visibility of these inequalities. People in dominant groups do not realize inequalities, contrary to people who experience inequality at work. In this regard, veiled women who suffered from the headscarf ban are delicate towards the discrimination based on the headscarf, while veiled women who enjoyed the headscarf freedom could not attribute any discrimination to the headscarf issue. The women who experienced the ban are passive in the face of mobbing and the like. Women who did not face the ban are more assertive in claiming their rights:

> There are significant differences between the two in the way they perceive the events and the prohibitions. For example, I see our generation as a highly oppressed generation. But when new generations face something, they object to it. They say, "why are you doing this? I have rights." We are a generation that has been inhibited too much and found ourselves after this ban was lifted. (Aybike, 31, 6)

> If you have not witnessed how much hatred they have against you, if you are not forced to the toilet wall, you cannot understand it. My friends with headscarves from the younger generation say that I exaggerate. It is not an exaggeration because I went through it. Even if some people do not express their hatred openly, I can understand it. Those people are still doing whatever they can to prevent you from your rights. But as I said, there are different opinions here. Veiled women who have not had trouble with the headscarf disagree with me. (Derya, 33, 10)

Moreover, veiled physicians aspire to be more knowledgeable, hardworking, and successful in their profession during the ban. However, now, these aspirations started to fade away. Feeling obligated to be successful in the face of discrimination has given its way to be successful for the sake of success. Veiled women's perceptions of their profession have also changed. In Dila's words:

> The idea that we should never make mistakes because we wear headscarves was more dominant. Because if we made a mistake, they would say, "Look, this is how they all are." That is why we always had to be better, and we had to work harder. We could not afford to make a mistake. (Dila, 33, 7)

One question constituting the backbone of this thesis is to what extent female employment is affected by the abolition of the headscarf ban. Has female employment been increasing or remained unchanged? To have a clue on this, I directed the question of "Do you think that female employment in the public sector, especially in hospitals, has increased after the ban is lifted?" to the participants. Since they have an insider look, participants indicated what they observed, witnessed, or heard about the issue. There are various opinions about the change in female employment. 60% of the participants thought that female employment has increased after the abolition of the ban. Six of the participants did not believe there is an increase.

Overall, women who might have increased the female employment rates in the public health sector might be divided into five: physicians who came from the private sector, physicians who returned from abroad, physicians who returned to medical education through amnesty, physicians who graduated but stayed at home, and veiled students who entered the medical school after the abolition of the ban and became physicians. Asiye explained the first group:

> Of course, it is possible to switch to the public sector. It must have happened. Because they worked in the private sector out of necessity, and the private sector conditions were more stressful and low-waged than the public sector. Since the ban has been lifted in public institutions, some physicians might have benefited from this. (Asiye, 27, 2)

The situation of physicians who returned to medical education through amnesty, in a parallel vein, was described by Hatice:

> An acquaintance that used to start faculty and could not attend due to the headscarf and dropped out of school and got married and had a child. She returned to school

> again with amnesty years later. There was someone else who returned like that; she graduated and started working as a physician. (Hatice, 29, 5)

However, some participants argued that since medical education is a challenging and long journey, the women who dropped out of university did not come back after the abolition of the ban. Thus, female employment rates did not increase due to the return of veiled physicians to the profession:

> She may not be able to return to her profession because she must enter the TUS, and it is not quite easy to succeed in the exam after 10 years have passed because TUS is a difficult exam. But she may have started as a general practitioner. (Meryem, 28, 4)

For the physicians who returned from abroad, participants gave examples of physicians from their circles who came back to work in the Turkish public health sector. Fatma is one of them. Since she could not study in Turkey due to the ban, she went to Austria to receive medical education. Then she came back as a physician. After the equivalency process, she entered the TUS and started to work. She described the return of her friends and herself from abroad as follows:

> Our friends from abroad went back to their schools and completed their education. They also started working after the liberation of the headscarf. We came here because the headscarf problem was over. We did not think of coming back until the headscarf issue was resolved. We came back with quite a few friends. (Fatma, 39, 7)

Although there are examples of women who became physicians but stayed at home, their number is few. In contrast, the women who have increased the female employment rates in the public health sector are allied health personnel and nurses in particular:

> I know many people work because they can work with a headscarf. But rather than the physicians, these people are intermediate staff, nurses. (Aybike, 31, 6)

> I am not sure. The medical community requires specialization. I am not sure if anyone has returned to the medical profession and specialization Because it simply takes too much time. If I were to quit, for example, I am not sure if I would return. Because when you are a 32-33-year-old, taking that long journey is a serious decision. (Derya, 33, 10)

However, Mine's case is noteworthy as she came back to the public sector after 16 years. When she was dismissed from her university position at the end of her residency, she founded her private clinic. After the abolition of the ban, she has returned to the public sector as an associate professor. Despite all the hardship, she worked hard and started her subspecialty education. In her own words:

> I was 180th in the exam. There was 176 vacant positions. Then I was admitted to the neurology subspecialty. My intention was pure, and Allah led the way. The headscarf ban was lifted in 2013, and I returned to the university as an assistant professor. It was hard to get back. I published my articles while everyone said that I, who as a woman gave a break for years, would not be an academic, could not pass the English test, cannot do this or that. I took the subspecialty exam because I was exposed to some mobbing when I was a specialist. By the way, I passed my associate professorship and foreign language tests. (Mine, 51, 29)

On the other hand, the participants who did not think there is an increase in female employment argued that most of the veiled staff was formally worked without a headscarf. They were already in employment. Therefore, although the number of veiled women in the public health sector has increased, women's employment rate has not changed substantially. Elif, for instance, who did not observe an increase in female employment, asserted that it is the number of veiled employees that increased, not the number of women in employment:

> Honestly, I do not think it will make much difference in terms of female employment. But the number of veiled women has increased, for sure. Maybe it is because we perceive them like that. It might look like they were too many. Maybe wearing a headscarf makes you stand out. I do not think it makes much difference. There were always women employees in the places we went to. It does not seem like there is a change in terms of numbers. (Elif, 51, 27)

Besides, a considerable number of women decided to wear headscarves after the abolition of the headscarf ban. Although these women desired to cover their heads during the ban, they did not do it because they did not want to put the headscarf on and regularly take it off.

> And after these events, some people started to wear the headscarf that I saw around me. Maybe, those who wanted to enter but could not enter because it was previously prohibited, because they did not want to put it on and take it off. But after that, the number of veiled people around me increased considerably in public hospitals. (Erva, 33, 10)

Finally, the leading group comprising the women with headscarves in public health employment is students who entered medical school after the abolishment of the headscarf ban. Since there is no ban, covered students choose medical faculty and become physicians. In Aybike's and Esma's words:

> But the rate of covered girls preferring this has increased very much. If there are 10 people out of 100 in our class, this number has increased exponentially. When we last left, almost half of the girls were covered. There has been an increase in covered girls' preference for these sections. (Aybike, 31, 6)

> But now I am looking at them, and they are higher in numbers. So, when the choice is offered, they decide more easily. They can enter the business and school environment effortlessly. (Esma, 35, 7)

It can be argued that the number of covered medical academicians has been increasing. The abolition of the headscarf ban paved the way for covered physicians to become professors through years of free education:

> With the increase of physicians in universities in the public sector, the number of covered physicians who made academic careers increased. I never used to see a physician wearing a headscarf in congresses. Now, at a big symposium, covered specialists and associate professors come out and lecture. Maybe if these women were forbidden, they would remain as practitioners and open a small practice or go to the private sector. It is not like that right now, and they will be able to reach the point where formerly they cannot come to professors' position. (Meryem, 28, 4)

Conversely, especially after February 28, the headscarf ban intensified, and numerous students from all universities suffered. Among these, medical faculties have a special place. Notably, the rector of that period started and inflamed the headscarf ban in the faculty of medicine at Istanbul University. Following that, the ban sprawled to other medical faculties. Accordingly, the media closely followed what was going on in medical faculties.

In this regard, when the connection between medicine and the headscarf ban was asked to participants, similar answers were received, and these answers mostly gathered around the mindset of medical professors.

As previously mentioned, Terzioğlu (1998) found that since physicians have access to medical knowledge and Western ideas and resources, they obtained a significant political role and regarded themselves as key players in the modernization process during the late Ottoman and early Republican period. By doing this, physicians formed a legitimate ground for their social and political judgments about society. In time, this ground is consolidated, and physicians kept expressing their political opinions. Accordingly, the harsh implementation of the headscarf ban in medical schools is explained by medical professors' justifiable confidence and assertiveness in expressing their political opinions for the sake of modernization. Ferhan's opinions about medical professors and the specific case of medicine in headscarf issues overlapped the arguments above:

> Physicians have always been a group of people who like to be involved in politics and a few other fields, rather than physicians. They are a group that is incredibly involved in politics. For example, one of our professors now studies in law school. Our physicians have a little bit of a tendency to think that they are an educated and intelligent group and set an example to their environment. I think they are prone to reflect their views to the environment, hospital, community, country where they are located. (Ferhan, 29, 5)

When combined with the TUS exam's absence, this mindset has continued with the physicians whom the medical professors chose. This situation put physicians with headscarves in more disadvantageous positions since their religious belief might not be welcomed by medical authorities. However, until the abolition of the headscarf ban, medical specialty preferences of physicians with headscarves were limited. In addition to specialty areas' features, these women mostly make their specialty choices based on the professors' views on the headscarf in the specialty area. Based on the participant narratives, it can be argued that the introduction of the TUS made some professors dissatisfied.

Parallel with the study of Genç-Kuzuca (2007) on gender discrimination and TUS. Participants stated gender inequality before the TUS. Covered physicians were discriminated against both for their gender and headscarf. Their chance of receiving residency education was lower than men and women without a headscarf in this connection. Ferhan, Güzide, and Meryem highlighted the issue as follows:

> That is why, for example, there were no such TUS or subspecialty exams during their student years; as our professors mentioned, they chose their students themselves. They became assistants like that. So, a certain point of view was handed down to future generations. The academic community has not changed now, as the professors of the 60s and 70s paved the way for assistants, minor associates, associate professors, and selected people close to their political views for academic staff. It continues in the same way; I can say that very clearly. (Ferhan, 29, 5)

> Until TUS came, the professors generally took the students they liked into their expertise. This directly allowed them to take the men of their mentality. For this reason, there were no Muslim men in medical schools. If there were any, they have to be accepted by accident or something. There were very few Muslim people. That is why nobody would have thought of working with a headscarf in medical school. (Güzide, 54, 32)

> It is always a psychological war. I am talking about 5th grade right now, it has been 2-2.5 years since the ban was lifted. That professor said, "After the TUS, bravery died. I cannot choose my assistant". (Meryem, 28, 4)

In a parallel vein, professors discriminated against some students in medical school, as participants argued. This ego problem stems from class positions based on race, ethnicity, and religiousness. Dila shared her observations during medical school:

> For example, one of the 9 siblings from Diyarbakır came to medical school. We witnessed a lot that some of our professors felt, "While my child is not, how can he be here?". Certainly, students in medical school have a privilege. People could not bear this privilege when they saw it in someone lower than them. Some of the people hurt inside while looking at us. Although we were lower class, for example, I was sitting at the desk where they could have their Ecole. This is intolerable for them. We did not deserve it; we should clean the houses, take care of the children. It was very traumatic for them that we got out of there. We did not deserve to do science. Because we already covered our heads and accepted the dogmatic understanding. (Dila, 33, 7)

> They roam around in the form of little gods of their own. Therefore, it is difficult to share that position. As medical professionals, we cannot improve the ego in character development and there is a problem in that regard. It stays a little crude. I think crude people accumulate more in medicine, so this fight goes on more. (Derya, 33, 10)

Çınar (2008) states that regardless of her class position, a covered woman is regarded "as the backward, the uncultured and uneducated, the rural, the traditional, the particular, the lower class" (p. 897). In this connection, participants asserted that medical faculty has a mindset that a religious person cannot be smart, or a covered woman cannot hold prestigious positions. In their own words:

> Medical faculty always accepts students with the highest scores. Therefore, they really cannot accept it. So how can a hardworking, intelligent person be covered and religious at the same time? They cannot accept it. A person who believes in Allah cannot be wise. (Elif, 51, 27)

> There is a professor who sees the headscarf as a physical obstacle to the development of science. He says information cannot enter because she covers her head. Literally. This is a professor. Very troubled, obsessed. (Derya, 33, 10)

> Of course, because the professors think they are the top segment of society. They regarded a physician wearing a headscarf as insulting to the physician's profession. Since he did not see me as the same, I was on an equal footing with him, and he was intolerant. (Mine, 51, 29)

As Saktanber (2002b) argues, "In the socio-political project of the Turkish nation-state, science was seen as the source of answers to people's existential questions, and religion was thus allocated no space whatever in the constitution of this new social order" (p.144). Therefore, the more a physician goes deep into science, the more he loosens his ties with religion. This also explains the relationship between the strict

implementation of the headscarf ban and medical faculty. Hatice describes this in her own words:

> It seems that a person who is engaged in science begins to concretize everything very much. You see that you can interfere with some things. Like you are adding a new gene to DNA. What I felt from the professors at the faculty was that "we can do these things." The more such materialistic, more concrete, explainable things were increasing a little more against Islam. The feeling that I can do everything. Therefore, things like Islam, belief, and "Allah created" are less accepted. (Hatice, 29, 5)

Although there is no headscarf ban, participants think the ban still exists in the medical faculty's mindset. Accordingly, if the political equation changes one day, medical faculty will express their thoughts on the headscarf:

> I think if the headscarf ban comes again, they will start talking. I do not think their opinion has changed. I think that the mindset in medicine and people with that mentality have not changed on this issue, they just keep silent according to the current conjuncture. Because you know that when there is any political conversation in the hospital environment, the opinions remain the same. In other words, when a ban comes tomorrow, I do not think that they will defend my rights. They just keep up with the current situation. (Meryem, 28, 4)

> I don't think everything is overcome in the community. Especially in the medical community. Being religious or belonging to any religion does not seem to coincide with science in our community since worship and religions are considered unscientific. I do not think they embrace it, it is not appreciated in the academic environment. If there is an opportunity, I may be asked to unveil, at least if the professors had the right to speak. (Derya, 33, 10)

After all, the participants of this thesis are physicians who are currently working. To measure the impact of the abolition of the headscarf ban, participants were asked would they do their profession even if the ban had not been abolished. Among 14 participants who answered the relevant question, 10 physicians stated that they would perform their profession in alternative ways. While some participants would receive specialty education in private universities that allow the headscarf and work in polyclinics, clinics, or private hospitals afterward, some participants asserted that they would go abroad for specialty education and work. Asiye explains her reasons why she would continue to do her profession:

> I guess I would have done it even if the ban had not been lifted because I would like to. It is a different profession for me, and somebody must do it, male and female. It is a profession that needs people of both sexes. (Asiye, 27, 2)

Moreover, one participant would proceed with bone since she has a surgical residency and spends most of her time in the operating room or delivery room. On the other hand,

one participant would do her residency and compulsory service without a headscarf and then try alternative ways.

Three participants asserted that they would not work. Their reasons to do so are various. While one participant would not work because she has no financial difficulties, Nevin attributed this to her profession and the need for a religious physician. She continued to work first with a wig and then with a headscarf during the headscarf ban, and she still works. She explained the reason behind her decision as follows:

> If I had not been a physician, I think I would not have worked independently from wearing a headscarf. After that, I think I would not have worked if I had not been a physician, whether there was a headscarf ban or not. You must be here; you are needed. This is the reason for our decision to continue during the headscarf ban. Therefore, while everyone can work easily with a headscarf, I would not have worked if I were not a physician. (Nevin, 50, 27)

4.5 Being a Veiled Physician in the Public Health Sector

Since I examine veiled physicians' experiences in the public sector employment, I questioned the participants' entrance to the public sector. Although most participants work in the public sector because of an obligation, they are happy. As mentioned in the research design chapter in detail, if a physician decides to be a practicing physician, he must do compulsory service in the public sector for two years. The other option, doing a residency, also requires being in the public sector since residency education is received only in the public training and research hospitals and university hospitals. Although there are private universities for residency education, there are more educational opportunities in the public sector. Again, there is a two-year compulsory service after specialization. Therefore, a specialist physician should work in the public sector for years. In this regard, most participants do their specialties or compulsory services in the public sector meantime. Fatma and Asiye summarized the issue as follows:

> We do not have many options. If we want to specialize, we must work in the public sector anyway. Again, to work outside, you must finish your compulsory service in the public sector. In any case, we are committed to the public. You cannot open out without entering the public. (Fatma, 39, 7)

> This is the point where medical school differs slightly from other departments. There is both a job guarantee, but the state is asking you to work first for it. He says you cannot work in the private sector. (Asiye, 27, 2)

Besides, the participants who finished their residencies and compulsory services decided to stay in the public sector due to the public health sector's better conditions. The advantages of the public sector for physicians overtake the disadvantages. The primary advantage of the public health institutions for participants is working hours, which is regular, and fair compared to the private sector. Therefore, female physicians could balance work and family life to a certain extent.

Also, wages are high. In the private sector, patients are regarded as customers, and medical services are given accordingly. Since the state pays wages, physicians in the public sector do not worry about their earnings and only concentrate on their profession. Moreover, as patients mainly apply to public health institutions, the patient variety in the public sector is higher. Being a physician in the public sector is more instructive in that sense. On the other hand, dealing with numerous patients from different backgrounds may cause violence against physicians.

As stated previously in the research design chapter, healthcare is done with a team of several different occupation groups. There is teamwork and, accordingly, a hierarchy in medical care. To grasp health institutions' operating mechanism, I directed questions regarding teamwork and hierarchy in the workplace to participants. Asiye explained the system as follows:

> There is certainly teamwork. You are a team with your department, and you always need each other in a hospital because a patient needs all. They can have many diseases, they may have additional problems, so you may need help from every department. There are physicians, nurses, allied health personnel, and there are personnel who prepare patients' bed, clean their room, bring them to the examinations, take their blood, take radiographs of patients, and record them. (Asiye, 27, 2)

In training and research hospitals, where most participants work, labor division is based on a hierarchy between physicians. The hierarchy is determined by medical expertise. There are medical professors at the top, and they are followed by associate professors, specialist physicians, and assistant physicians. This hierarchy facilitates learning and sharing the responsibility of patients at the same time. The hierarchy is highest in training and research hospitals, among others. On the other hand, in family health centers, the team comprises a physician and a nurse. It should be added that

according to Acker (2006, p.452), the legitimacy of inequality depends on the organizational structure of a workplace. In this connection, inequalities based on gender, class, and the headscarf are legitimized through this medical hierarchy.

To follow the social relations within these structural hierarchies, I asked participants whether they witness any social hierarchy and, if yes, in what ways. In conclusion, I have found that social hierarchy in the medical workplace is shaped mostly by seniority, which is the spent years in the profession. In this connection, an assistant physician who entered the profession even six months before another assistant physician is the latter's senior. Social hierarchy work in this way. Bilge stated that especially newcomers do not welcome this kind of hierarchy:

> Hierarchy is indispensable for us because it progresses with the master-apprentice relationship, on a seniority basis. If someone started first with even a day before, then he is a senior for those who start after. He does what he says, and cannot resist. It is based on social hierarchy; we all complain about it. Especially beginner friends complain. Regardless of age, although our apprentice is older than the senior, the seniority is felt socially. But as far as I can see, the social grouping is also generally based on seniority. Those who entered the same year, those whose seniority were close to each other are more grouped. The higher ranks are more among themselves. This, I think, directly reflects on social life. (Bilge, 31, 4)

Additionally, age and gender make physicians vulnerable in the medical hierarchy. Women physicians experience mobbing regarding marriage and having children, as will be analyzed soon after. In terms of age, there is usually tension between a young assistant physician and an old nurse since the nurse is not comfortable with taking orders from a younger physician, as Asiye argued:

> Yes, you may be hierarchically higher, but the fact that the other party is older than you may affect your social relations a little. The orders you give him can make him uncomfortable because, in terms of age and seniority, it is the nurse who is superior to you in years, but you are the physician no matter what. You are superior in terms of patient management. They apply the tasks and treatments you give; they are obliged to do what you say. They can be social differences. (Asiye, 27, 2)

As stated earlier, healthcare institutions have the highest division of labor and diverse occupation groups. Physicians, the core of healthcare, work together with other physicians, allied health personnel, and administrators to treat patients. Therefore, they establish several relations. One aim of this thesis is to reveal the relations of veiled physicians with the groups above and the headscarf's role in these relations. Regarding this, participants stated that they are on good terms with each group. However, patients

and administrators are the two groups that physicians found challenging to work with. Since administrators mostly act like business managers sometimes, physicians try to avoid administration as much as possible. Also, physicians have difficulty in persuading patients and expressing their diseases to them.

When it comes to the headscarf's impact within these relations, a considerable part of the participants stated none. Similarly, when I directed the question of "Do you think you have encountered any different treatment because you are wearing a headscarf?", 12 of 18 participants asserted that they do not encounter any different treatment. However, as the conversations proceed, different outcomes were revealed. Participants who do not experience discrimination based on the headscarf attribute this to their residency and health institution preferences and, consequently, the patient profile. Since they had difficulties based on the headscarf in the past, participants avoided any place where they might encounter negative attitudes regarding the headscarf. Bilge gave her story as an example:

> It was the reason why I chose the hospital where I work. As I expected, I did not have any problems. I experienced problems in the past, and I did not want to go to Hacettepe, fearing it will happen again. I did not apply to it even though I had enough score for it. (Bilge, 31, 4)

Similarly, Ceylan and Ayşe explained their comfort with their hospitals and the patient profile:

> I have not encountered such treatment much. But of course, it may be related to the patient profile. In the environments I work, I generally work in more public, middle-level state hospitals. However, if it were a university hospital or a private hospital, it could happen. It is about the patient profile. (Ceylan, 43, 19)

> I do not think in these institutions, as in the public hospitals. But if I were in Hacettepe, then I would think. It may be related to the comfort of the environments where I work. At the hospital where I am now, I did not have any problem concerning the headscarf. (Ayşe, 33, 7)

On the other hand, some participants explained this non-discriminatory environment with intervening years and people who got used to the presence of headscarf. In Ceyda's words:

> I think there was a prejudice against those who wear headscarves. Because the only people they saw with headscarves were cleaners, aunts on the road, etc. This is how they perceived veiled people. They could not perceive much that a smart person, a cultured person, could wear a headscarf. They could not perceive that this was

> something we did of our own will, that we made such a decision with our free will, not the imposition of someone on us. They saw the headscarf as oppression. I think they got used to this thought too. (Ceyda, 26, 2)

Apart from these, some participants stated that they experienced positive discrimination due to the headscarf. Patients are pleased to be treated by veiled physicians quite often. Since patients see veiled physicians as one of them, they trust them more and show their contentment. Again, it should be stated that the patients who exert positive discrimination to veiled physicians have religious backgrounds.

> But you feel that she identifies you with herself. She came out of the village; she sees you as someone with whom she can build rapport. I saw a lot that they did not confide their troubles to other friends but me. (Bilge, 31, 4)

> If you are veiled, patients think you will tell fewer lies and make more just choices. The patient starts with a sense of trust when the physician is wearing a headscarf. I was in Haymana State Hospital for three years. I think it adds a little more positivity to me in terms of patients. When the patients come in, if you wear a headscarf and establish a good social connection, you start with +2 from the beginning if you have a smiling face. But it is not like that for academia. It is uncomfortable. (Derya, 33, 10)

Therefore, it can be said that the headscarf becomes an instrument and facilitates the physician-patient relationship. In this sense, the headscarf reduces gender inequality in some cases.

On the other hand, patients are not always welcoming veiled physicians. Some patients cannot imagine a physician with a headscarf. In some cases, patients question veiled physicians' capability and could not take them seriously. As Asiye argued:

> There may be people who think that veiled people can only study divinity. There may even be people who think veiled people cannot get into universities. They are surprised that you became a physician, studied, and succeeded. (Asiye, 27, 2)

One prominent occasion that veiled physicians came across is patients' expectations of veiled physicians. Patients attribute particular meanings to the headscarf and accordingly have assumptions of how veiled physicians behave and act. When their expectations are not met, patients initiate discussions and attack the headscarf. Furthermore, any discussions between patients and veiled physicians might turn to the headscarf issue:

> If there is another problem, he is not satisfied with his treatment or room or something else. In such a situation, I have seen that the discussion is directed to my headscarf. "And ashamed of your headscarf! You are covered up like this! These veiled ones are like that!". If there is a problem, I saw that discussion turns into my headscarf, as if

> the cause of this distress were me. He verbally insults me, says “an idiot.” After a while, it turns into the headscarf. For example, he is not waiting for his turn, demanding another turn, or he is stealing someone else's turn. This is something unfair. When you refuse, that thing can turn into your headscarf. This is something strange that I experience while working. (Aybike, 31, 6)

> There is no headscarf effect, but when they get angry with something else, they talk about our headscarves. "Does it suit you at all as a veiled?" Probably when they think we are not fair. Their understanding of justice is quite different. Probably what they expect from us is to behave conscientiously. When we wear a headscarf, they think that we have to do good for them. (Elif, 51, 27)

> I was subjected to such an insult by a patient walking over me and saying, “why are we waiting here, what are we waiting for” and “and ashamed of your headscarf”. When we wear a headscarf, do we need to make an extra effort for people? Should I not have done it when I was wearing a headscarf? I do not know what he implied. (Ferhan, 29, 5)

> "Look at that thing on your head, and you also wear a headscarf." kind of phrases have been heard. One of my patients argued with the intern friend working with me. She was preventing him from working. Then her husband came in and continued this discussion. Queue discussion. After saying many things, he said something like, "And look at that headscarf on your head." By the way, his wife is also wearing a headscarf. (Dila, 33, 7)

Besides, there are cases when patients use religious phrases to request additional treatments, as Mine pointed out:

> Many people use it: "Would you do it for the sake of Allah?" For example, it happened in the morning, "my professor, for the sake of Allah." If I give you consent, I must give the others, then I said, is it fair? We are expected to be compassionate; extra conscience and tolerance is required. (Mine, 51, 29)

On the side of physicians and professors, however, attitudes towards the headscarf are different. Participants asserted that although they do not encounter any problem regarding their headscarf in the workplace, they still face their professors' and colleagues' prejudice. In other words, physicians with headscarves experience discrimination from professors and colleagues based on the headscarf implicitly or explicitly. Considering that professors are not a homogenous group, generalizations should be avoided. However, due to the specific characteristics of the medical profession and Turkish physicians' role in the modern nation-building process, medical professors have a specific position in the face of the headscarf issue, compared with professors of other faculties. Besides, medical professors are the group that participants stated as the primary source of discrimination based on the headscarf in their work life.

After the lifting of the headscarf ban, there was a transition period in which the decision to accept the headscarf was left to professors or the administration. Therefore, while some students in certain universities could wear the headscarf right after the annulment, some students had difficulty in wearing the headscarf at university or hospital. Still, the perceptions and attitudes of medical professors towards the headscarf issue have not substantially changed. Mobbing, discrimination, and harassment persisted. In the period after 2011, veiled physicians were mostly ignored or humiliated by their professors, especially during the internship period, when the interaction with professors and patients is highest.

Nevertheless, they faced less discrimination during practice. This finding overlaps with the literature on the relationship between medical hierarchy and gender discrimination. As Frank et al. (1998) revealed, gender discrimination and sexual harassment are more frequent during training than practice since female students occupy lower levels in the medical hierarchy during training and move up in the hierarchy as they become physicians and the like.

In a parallel vein, veiled physicians experienced discrimination based on the headscarf more during training than practice, even after the abolition of the headscarf ban. However, this discrimination continued as physicians with headscarves were in contact with professors, even during practice:

> Then, the next year, everyone was wearing a headscarf, and we started to do so. That transition period was a little troublesome. During an internship, you are divided into groups, up to 20 people. You are visiting a service with a professor. The professor could say that if you do not uncover your headscarf, he will not do the lesson. As such, you feel responsible for other people, and you must go. (Hatice, 29, 5)

> Our small group lessons were 5-6 people. For example, we do 1-hour small group lesson with six people with a professor. For example, there were situations that some professors ignored you, asked questions to everybody, and were never addressed. Of course, this situation affects human psychology. At that time, I decided to go abroad. (Ferhan, 29, 5)

This finding could be analyzed through the concept of "organizational control" of Acker (2006, p.454). Due to the hierarchical structure of medical education and work, organizational control people occupying higher hierarchy levels are internalized, thus normalized. Accordingly, the organizational control based on medical expertise and

the discrimination based on the headscarf could intermingle. Therefore, headscarf-based discrimination becomes difficult to be noticed.

The majority of the participants expressed their grief about the negative attitudes of their professors towards them. Notably, medical congresses are places where one can see the remnants of the headscarf ban and the anger towards the headscarf:

> I think that there will be a serious exclusion in the medical community whenever they take the opportunity. I do not think that it has passed. When you go to a medical congress to present a poster, you see that everyone is looking as I am extrinsic. For example, more people come to that session to listen because they will criticize. They want to see your failure to explain, to see your faltering. There is an expectation about your loss. Alternatively, when I attend a medical congress, professors make a political speech. We follow something about radiology there and suddenly, the professor gets into a political issue. "This nation is a maniac; these folks are stupid." The hall applauds like crazy. I attend a session with gratitude: on the one hand, I think I could not be here before with a headscarf. In a session that I listen to with such enthusiasm, the people turn to you and applaud you in protest. And you say, oh my Allah, if there is an opportunity, my academic effort and I will still be denied. (Derya, 33, 10)

Mine, who came back to medical faculty after the abolition of the headscarf ban, stated that nothing much changed in the medical faculty:

> When I came to Ankara for my subspecialty, I was the only woman wearing a headscarf. Some of the professors did not even address me and say welcome. We were the people with whom they could not even make eye contact and could not tolerate. These still exist. They only tolerate now. I think they did not get used to it; they are only tolerating it. If the political system changes, they will not accept us again. (Mine, 51, 29)

Then, it can be argued that physicians with headscarves do not face headscarf-based discrimination of people below in the medical hierarchy but are mobbed by people who are higher than them in the hierarchy. Acker (2006, p.445) uses the term "steepness of the hierarchy" while explaining the relationship between hierarchy and inequality in the workplace. In workplaces with hierarchical structures, inequality is more probable. Considering the hierarchical nature of medical work, this kind of inequality based on gender and headscarf is no surprise. For instance, Ferhan stated that her colleagues from different worldviews do not treat her differently. Yet, the same thing is not valid for her professors:

> Of course, since there is seniority, it did not harm me down below in the hierarchy. I have not seen anything like that in our specialists regarding the headscarf. It still makes a difference in terms of sincerity and approach from the professors. I feel that they keep their distance from me. The opportunities offered to non-veiled friends and

> us are also different. You can still feel it for education and everything that is up to the professors' initiative. Tolerance towards us is much less than for friends who are not veiled. You feel this at the point where the professors will exhibit a behavior—the professor's approach, not a negative approach from the outside. But there is a strange distance, timidity. There is something between him and you. He put something there, a distance. (Ferhan, 29, 5)

Although not as common as professors, colleagues also prejudge veiled physicians and act differently, as in the examples of Derya and Elif:

> If their political ideas or perspective on Islam are negative, the dialogue begins with prejudice. But when you work together, you are in a constant state of self-proof. I am fine. I am hardworking. Such a thing does not give you the right to mistake. You are more criticized. They expect more. In other words, it is necessary to be more professional, loving and gathering. I do not know; you need to put your human qualities more forward. Even if he thinks negatively, after a while, even if he has a very contrary lifestyle to yours, the conversation goes very well with a colleague. But in the first place, there is a general prejudice that "she is not like me." If you disagree, there is prejudice. (Derya, 33, 10)

> It was like this, for example, when we had a complaint or when we wanted something for work, when we say something about ourselves like "Let us do that too, let us do this, let us get this training too": "Be thankful for working like this, wearing a headscarf." they said, I remember this very clearly. (Elif, 51, 27)

Also, mobbing based on the headscarf wore veiled physicians out and ended up with veiled physicians' resignation in some cases. For instance, Ferhan was exposed to mobbing for a month and verbally abused by her senior every day from day one:

> I did an intensive care internship for a month. I was verbally abused every day from the day one. I think I had accidentally entered his room the first day without seeing it. It was our first day in intensive care. "You cannot enter this room. This room is mine," he said. During the next month, there were all kinds of mobbing, insults at the visits. Because it happened from the first day, I had the same thing in another rotation for one month in my assistantship. So, what can we attribute this to? Because he has not seen my work, has never been in dialogue with me, does not know me. Only my worldview is evident. Maybe this has damaged the relationship between my profession and me. (Ferhan, 29, 5)

4.6 Being a Female Physician in the Public Health Sector

In terms of residency preference based on gender, participants stated similar opinions in line with the literature explaining residency preference based on gender with a gender socialization perspective. According to this perspective, as mentioned in the

literature review chapter, men and women acquire different gender roles at home and work. Therefore, physicians prefer specialties in accordance with their gender roles.

In this connection, participants argued that men are mainly gathered in surgical specialties as these specialties are harsh and require long working hours and strength. Orthopedics and urology are other specialties that are male-dominated. On the other hand, women physicians prefer comfortable specialties with fewer night duties, as they also want to fulfill their motherhood obligations. All in all, men prioritize income and women prioritize work-family balance, according to participants.

Nevertheless, some participants argued that this gender division in medical specialties has been diminishing since men also have started to prefer specialties in which they work with less effort. Ceylan explains why:

> Men mostly prefer surgical specialties; women are relatively more comfortable. But my period was quite different from this period. When I chose a residency, women were generally gynecologists, and men were mostly in surgical-cardio-internal specialties. Now, this has changed a little more. The main criterion in choosing the residency for everyone is, which may cause less legal problems, which department can be legally more comfortable. (Ceylan, 43, 19)

When the headscarf's impact on residency preference was asked to the participants, they argued that although it had an impact, this impact disappeared. Formerly, veiled women mainly preferred gynecology and obstetrics to treat female patients and, therefore, to meet the need for female physicians for female patients in that branch. However, as can be seen from the participants' residency choices from different generations in this research, veiled physicians do not concentrate on certain specialties but prefer diverse specialties now.

The gender distribution of participants' medical specialties showed that participants mainly occupy specialties where women are in the majority. While eight physicians are in women-dominated specialties, four physicians have equal numbers of female and male staff, and three physicians' specialties are male-dominated.

Physicians with headscarves also encounter difficulties as women in medicine. As one participant stated, not only women wearing headscarves but also women, in general, should work at least twice as much to express themselves in the working environment. Participants particularly highlighted some common points of what they experienced in

the workplace as female physicians. One salient thread is patients' attitudes towards female physicians. Patients treat male and female physicians differently. In line with the literature on violence against female health personnel, patient and patient relatives use violence against female physicians more liberally. For instance, patients raise their voices to female physicians easily compared to male physicians.

> Of course, being a woman is a disadvantage here. In other words, when a male physician comes across the patient's relative, the attitude of the patient's relative and the self-confidence of the male physician are not the same as women. He can defend his rights much more, but you step back more since you are a woman. This is partly due to society; if you show your strength, the other person will step back. When you cannot show your strength, they come down on you. (Ceylan, 43, 19)

According to the literature, female physicians have different communication patterns than male physicians. Therefore, they are more likely to encounter violence. Similarly, the research findings showed that as female physicians get in more contact with patients, they are relatively more open to any verbal attacks on patients' side. Aybike explained the reason behind patients' negative attitudes towards female physicians as follows:

> The more you communicate with patients, try to explain the situation, the more you give to the patient, the more you get. Not all that you get is good. If you do not deal with the patient, if you make no account of the patient, you will never have any problems if you give the image that you can protect yourself physically. (Aybike, 31, 6)

Although all women in medicine face discrimination based on gender, women in some specialties are more prone to be exposed to violence, as participants argued. For instance, in pediatrics, gynecology, and obstetrics, the relations with patients' relatives are harder to keep up. Dila and Erva mentioned the situation in these residency areas:

> For example, since our patients' relatives are husbands, fathers, or men, the probability of using verbal or physical violence against us is much higher. While they cannot blow up comfortably to male physicians, they do to us more easily. (Dila, 33, 7)

> While meeting with distressed families, I had to take a male physician or a male staff with me. There was also a patient walking up to me. I sometimes take a male staff, especially a male assistant, while meeting with patients' relatives to feel safe. Since we are female physicians, some patient relatives, especially fathers, can attack physically and mothers verbally. (Erva, 33, 10)

What is more, despite the increase in the number of female physicians, people do not regard women physicians as physicians but as nurses at first glance. The sense of

gendered profession is still strong in our society. People still do not assume that a woman could become a physician:

> I had encountered many patients, mostly when I was in an emergency unit. In general, there is a perception that women are nurses, and men are physicians. For example, although I examined the patient, they insisted on calling me a nurse lady. When I said that I am not a nurse, they used to say "Mr. physician" or "Mr. physician lady (*Doktor Bey Hanım*)." (Ceyda, 26, 2)

> He even calls me Mr. physician. We had a child who called me Mr. physician aunt lady (*Doktor Bey Hanım Teyze*). On the committee, he used "Mr. Aunt Mine Lady," such a thing. He cannot imagine that. They are so used to the male physicians. (Mine, 51, 29)

> In our society, there is a concept called a male physician. The patient's relative saw me and called me Mr. physician. I was a service senior and had 6 people under me. Seven of us were sitting in the physician's room. We were making a service plan when the relative of the patient entered. By the way, 6 of these seven people are female, and one male is the last year's student. So, the lowest in seniority. The relative of the patient is also male. He entered the room and looked at all of us. He found that man and told him. I was the person to answer that question. I was angry, so what happens when he is a man. Then my answer was: "Ask me your question. I am the service manager." Then he started talking to me. (Ferhan, 29, 5)

Besides "Mr. physician," veiled physicians are also called through kinship terms such as sister or aunt. As Kandiyoti (1987) argued, Turkish women's gender roles and professional roles are intermingled, and this caused confusing situations. Specific cultural mechanisms are used to make cross-sexual encounters sexually neutral, such as using kinship terms of sister, aunt, or mother according to the respondent's age. According to participants, although it might be due to patients' effort for creating rapport, it is a mark of lack of respect:

> They call a male physician: Mr. physician. However, they call me like, "my sister, aunt (*ablacım, bacım, yenge, teyze*)" have such nonsense expressions. (Kübra, 48, 20)

> Maybe it is because they feel close to us, but I think it is a lack of respect most of the time. (Elif, 51, 27)

Participants are not pleased with the prejudices against women in medicine. The literature argues that men and women have similar levels of medical knowledge. In a parallel vein, Derya argued that there is a misconception regarding men as perfect physicians while considering women as inadequate:

> I think men are not as 100% professional as they think. We all have our weaknesses; we are human beings. There is no point in putting the man in an incredibly favorable

> position and making the woman very traumatic. I think a focused woman will do her job very well. (Derya, 33, 10)

As the last question, I asked participants whether they think female physicians and veiled physicians, in particular, are treated equally in education, career, and promotion. About 40% of the participants thought there is equality between men and women in medicine career progress. They argued that there are criteria and requirements for promotion, and consequently, gender has no impact on it. Also, career advancement is more about personal effort, i.e., personal connections, as Derya stated:

> A career depends very much on your effort. In a career, whether as an associate professor or assistant professor, rather than a woman or a man, personal connections, political connections, professor acquaintances work a lot. To become an associate professor, networks are instrumental. Therefore, even when you go to an associate professorship exam, if the jury knows the person you know, greetings, and phone calls in the mornings, you can easily pass through that exam. So, I do not think there will be an advantage or disadvantage of being female. (Derya, 33, 10)

On the other hand, other participants indicated how being a female in the health sector affects their career development. They argued that there is no equality of opportunity, although it is said so. Since women do house chores and become mothers, they are not mostly welcomed in the health sector. Especially when they get married or have a child, it is believed that the medical system will be interrupted. Therefore, female physicians face severe mobbing based on marriage and giving birth:

> Equal opportunity does not exist due to the conditions of life. When I first started working, there was a physician in charge at that time in Kazan. He saw me, not as a veiled, but as a woman. “I do not like the female staff at all,” he said. "Her child becomes sick, she gives birth, things do not work here when a woman does not work," he said. However, I was more hardworking than other physician colleagues there. (Kübra, 48, 20)

> I think so because they cannot devote as much social responsibility to this job as men do. Frankly, if women spend the same energy as men, I would not see a significant difference. I think they could come to the same place if they would spend the same effort and get the same permissions. (Ayşe, 33, 7)

> Women have a pregnancy situation; they go on maternity leave. Our superiors are always uncomfortable about this. When I started being a minor assistant, my professor said: “Do you have a child? Yes, I have. Do you think of any other children? No, I do not think. Ok, we do not want you to think about it." So, pregnancy is not welcomed here. We are on duty here; I am keeping seven days of the 30-day shift. They do not want to be deprived of such a workforce. They are right. But I think we are right either. I mean, I do not think my professor should decide whether or when I will have children. (Erva, 33, 10)

> Professors prefer male assistants more in surgical departments. Some specialties do not want female assistants, especially stating this because they have maternity leave and breastfeeding leave. For example, when I meet them to apply some specialties, some departments provide conditions so that you will not give birth to children if you come here. Or, there are departments whose only condition is being male. (Ceyda, 26, 2)

These findings align with Acker's (2006) explanation of how the organizing process causes gender-based inequalities in the workplace. Organizing the general requirements of work is among the factors resulting in discrimination based-on gender since work is mainly organized according to a "white man" who has no responsibilities other than work and could easily give himself over to his work (p.448). In this connection, women physicians who try to balance work and family lives are mostly obliged to renounce their career or comply with the work lower than their expertise and the like.

In terms of academia or executive positions, women physicians are disadvantageous and, therefore, less in numbers than men. It might have several reasons, according to participants. On the one hand, women may not prefer these positions since they look for work and family balance. On the other hand, although they prefer, gender discrimination might disclaim women physicians. As Asiye stated:

> When examined, the number of women associate professors or professors is less than men. This can have many factors. But women's jobs are more demanding in terms of progress. Because many places do not want a woman physician. It can be thought that women cause more trouble, it can be with the part related to pregnancy and the part that thinks that women may be more sensitive and take more leave. I think they have disadvantages in that sense, I think women are more held back. (Asiye, 27, 2)

Güzide, on the other hand, explained this issue with male unity in business life in which men favor each other and exclude women:

> I think men always watch out for each other for administrative stuff. You will see in business life; they look after each other in such things. I do not know if we would look after each other, but I always see it. Men are more flexible with each other. (Güzide, 54, 32)

In sum, veiled physicians faced severe discrimination based on a headscarf during education and, in some cases, during practice at the time of the headscarf ban. The mobbing they were exposed to negatively affected veiled physicians' attachment to their profession. After the abolition of the headscarf ban in public institutions, physicians started to work with their headscarves, and some veiled physicians

transferred to the public health sector from abroad or the private sector. Among these, veiled physicians who experienced the ban and did not witness any kind of headscarf-based discrimination have different perspectives of the medical profession and the headscarf. Physicians who encountered discrimination more and especially experienced the February 28 still have traumas regarding the ban and are more sensitive about perceiving discrimination based on the headscarf. Despite the seven years of headscarf freedom, veiled physicians are still anxious because of the possibility of returning the ban one day and the medical faculty's possible actions accordingly.

Although physicians with headscarves experienced discrimination based on a headscarf during the transition period right after the abolition of the ban, today, they freely perform their profession since they made their residency and hospital choices accordingly. However, they still encounter mobbing from their professors, i.e., people above them in the medical hierarchy to some extent.

Other than that, veiled physicians face challenges as women in a medical workplace. These challenges are mostly directed from patients and their relatives in physical or verbal violence or from male colleagues against female physicians getting married and having children. Although there is gender equality in both male and female physicians' career advancement, female physicians fall behind their male colleagues in academia and executive positions due to a lack of equal opportunity.

CHAPTER 5

CONCLUSION

Wearing an Islamic headscarf became an issue with the late Ottoman and early republican periods' modernization process. This issue became a key point for women with headscarves as the first legal headscarf ban was implemented in the 1980s. The headscarf was banned in higher education and, one year later, in public institutions. Many women with headscarves were either expelled or forced to resign from their jobs. The headscarf ban reshaped the educational and work lives of women with headscarves until its abolition in the 2010s.

It has been 7 years since the headscarf ban's abolition. Women can receive education and work in public institutions with their headscarves. One may think that veiled women have no problems due to the headscarf anymore. However, combined with gender discrimination, women working in public institutions with headscarves face discrimination based on the headscarf. The negative impact of the years-long headscarf ban seems not to be eradicated in a short time.

In this connection, this thesis aimed to examine the experiences of Muslim women physicians with headscarves in public health institutions in Turkey after the abolition of the headscarf ban. To reveal veiled women's experiences throughout their inclusion in public employment, I set the main research question of this thesis as "How the headscarf issue shaped the experiences of women physicians with headscarves in the public health sector after the abolition of the headscarf ban in Turkey?"

By examining veiled women physicians' public workplace experiences, I also aimed to answer the following sub-questions throughout the thesis: How and in what ways does the headscarf affect veiled female physicians' work-life? How and to what extent the prior headscarf ban affects the work-life of veiled female physicians? For instance,

does it impact veiled physicians' decisions on selecting their occupation, their field of specialty, their workplace, and the like? What specific do explicit and implicit barriers to progression veiled physicians identify at different stages in their careers?

Analyzing women's inclusion with headscarves in public employment through a specific focus on physicians has several reasons. First, the number of women working in the public health sector is very high. In the second place, the medical profession is a prestigious profession requiring great work, effort, and dedication. As a result, physicians are always in demand in the labor market, get respect from patients, and receive high salaries. In a setting where women with headscarves are prestigious as physicians in the public sector where they were expelled before, the social and political dynamics intermingle. This complex set of relations constitute different structures that include both professional success and gender discrimination.

Third, Turkey's medical education system requires physician candidates to do compulsory service in public health institutions after graduation to become a physician. To put it differently, a veiled physician, either during medical education or compulsory service, faced with the headscarf ban before its abolition, to become a physician. Due to these reasons, veiled physicians constitute a favorable group to investigate the state of women with headscarves in public employment after the abolition of the headscarf ban.

By asking the right questions, I tried to reveal the impact of the headscarf and the previous headscarf ban on veiled women working in public institutions, if any. Medical work has a hierarchical structure based on medical knowledge and practice and is essential for patients' treatments. This hierarchical structure has its dynamics besides medical knowledge. Social, political, and cultural opinions of medical personnel find their way through the medical hierarchy. Exploring the headscarf's impact on the relations in the medical hierarchy was another focus of this thesis.

To seek answers to my research questions, I utilized qualitative research methods. Since the labor force and employment data do not categorize women as veiled or not, quantitative research was not possible for this study to track the change in the number of women in public employment after the abolition of the headscarf ban. Although the findings gathered through qualitative research cannot be generalized, it enables us to

trace the various experiences of veiled physicians regarding the headscarf and the specific discrimination they have been facing. In this connection, I conducted semi-structured interviews with 21 women physicians with headscarves working in public health institutions in Ankara from February to March 2020. Of 21 participants, 10 are specialists, 9 are assistant physicians, and 2 are practitioner physicians.

One objective of this thesis was to discover the intensity of veiled women's exposure to the headscarf ban and its possible consequences on veiled physicians' professional lives. For this reason, I divided the participants into two groups: physicians who experienced the February 28 process while working and who did not. While the first group has spent up to thirty years in the profession, the latter has spent ten years maximum. I assumed that the veiled physicians who experienced the February 28 process during their work lives have different workplace experiences and perceptions of and expectations about their profession.

While seeking an answer to my research questions, I found that even after the abolition of the headscarf ban in public institutions, the headscarf influences veiled physicians' workplace experiences. This impact could be both negative and positive. The prior headscarf ban greatly affected veiled physicians' decisions on selecting a medical profession, their universities, their residency area, and their workplace. Veiled physicians made these decisions in such a way that they are least affected by the headscarf ban. Therefore, today, veiled physicians carry the traces of the headscarf ban in their professional lives. Sayan-Cengiz (2016) argues that after the abolition of the headscarf ban, 'the "headscarf experience' can no longer be idealized in the storyline of educated, middle-class women's struggles to get state recognition to an excluded identity" (p.13). However, based on this thesis's research findings, I argue that veiled women still strive to gain society's recognition. The veiled physicians' experiences showed that the prior headscarf ban's negative impacts had not been eradicated completely.

I found that veiled physicians' negative education experiences during the ban affect their work performance and attachment to their profession. Since veiled physicians limited their time spent on university campuses, they did not attend non-compulsory classes or students' clubs' social or scientific activities. Therefore, they lacked informal

interactions with their professors and peers, resulting in less medical information circulating through these informal interactions.

On the other hand, due to the government's everchanging health policies, physicians' working conditions deteriorate. The scope of their rights is decreasing, and responsibilities are increasing. When combined with the medical profession's harsh working conditions, veiled physicians do not find the energy to cope with the workplace problems they face. The struggle they had during the headscarf ban in education impairs the participants' professional enthusiasm. After having difficulty due to the headscarf ban during education, veiled physicians mostly feel disappointed with their current medical professional situation. However, this is not the case for all veiled physicians, for sure. After years of struggle for headscarf freedom, veiled physicians are glad to work with a headscarf and love their profession, despite hardships.

Since 2013, after the abolition of the headscarf ban, the effects of the headscarf on veiled physicians' work lives continued to some extent. Especially in the period right after the abolition of the ban, veiled physicians experienced headscarf-based discrimination from their medical professors. Veiled medical students were expelled from classes, humiliated, and harassed despite the headscarf freedom. However, the tension between ban supporters and the veiled physicians has decreased as time passes by. Nevertheless, veiled physicians still feel worried about the headscarf ban to return, as I will explain shortly.

One of the present research's important results is the close relationship between the medical hierarchy and discrimination based on gender and the headscarf. As mentioned earlier, medical hierarchy constitutes the core of medical work in the workplace and affects and is affected by social, political, and cultural factors. Although participants stated that they do not face any headscarf-related discrimination, as the conversations proceeded, I found that people on higher levels of the medical hierarchy, professors in particular, still discriminate against physicians with headscarves in the workplace. However, veiled women do not encounter headscarf-based discrimination of medical personnel of their level or lower. Özipek (2008) argues that the headscarf ban is more related to power relations rather than legislation. Therefore, legal

regulations are not enough to lift the headscarf ban. Instead, political power in social, economic, and class-based relations determines the headscarf ban's fate (p.17). In line with this argument, I claim that the medical hierarchy has a negative impact on veiled physicians by legitimizing headscarf-based discrimination and enabling medical professors to actualize their social and political opinions against the headscarf.

On the other hand, medical professors' attitudes do not only stem from their higher position in the medical hierarchy. The strong link between modernization, secularism, and science also plays a crucial role in determining medical professors' perspectives on the headscarf. This link goes back to the modernization period of late Ottoman and early republican times when medical professors became an intellectual elite and guided the modernization project. This understanding continues in time, and physicians give themselves an authority to convey their political views to direct the society they live in. Secularism and science are counted among the pillars of modernization. Therefore, religion has no place in the medical workplace where advanced science is applied. In this regard, the Islamic headscarf, the sign-vehicle of religious beliefs of a woman, contradicts with medicine. Although the headscarf ban is lifted, medical professors do not welcome physician candidates with headscarves most of the time. That is why participants stated that they are subjected to discrimination based on headscarf more during medical congresses, where the latest medical knowledge is shared.

In this connection, I found that veiled physicians think if the political conjuncture changes and the headscarf ban is implemented one day, medical faculty will be among the first group who welcomes the ban and apply it. In retrospect, the headscarf ban was implemented harshly in medical faculties after February 28, such that most of the protests against the headscarf ban were run by medical students and had wide media coverage. As mentioned previously, Leyla Şahin, a medical student, applied to ECHR in her fight against the headscarf ban, and the court decided against her. In this regard, I argue that veiled physicians, especially those who experienced the February 28 process, could not overcome the headscarf ban's negative impacts and are still afraid of the return of the ban.

At this point, I should state that the medical professors are not a homogenous group. There are medical professors who support the headscarf ban and professors who

advocate the headscarf freedom. Therefore, generalizations should be avoided. Nevertheless, due to the medical profession's specific nature and the pioneering role physicians play during the modern nation-state building process, physicians possessed a different position in the face of the headscarf issue compared with professors of other faculties. The narratives of the participants confirm this argument. Participants stated that the medical professors are the main group in medical workplace who exert discrimination based on the headscarf.

In terms of patient-physician relations, veiled physicians do not have any headscarf-related problems with patients or patient relatives. On the contrary, they think that they experience positive discrimination. Since most of the physicians I interviewed with work in training and research hospitals, their patient profile does not stand against the headscarf. Instead, patients show their contentment to have veiled physicians. In some cases, patients feel more comfortable getting examined by a physician with a headscarf as they see the veiled physician as one of them.

Although veiled physicians have good relations with patients, the headscarf eventually enters the picture. When a patient discusses with a veiled physician for some reason such as queue, waiting too long, or treatment, the discussion sooner or later turns into a headscarf issue. The patient verbally attacks the physician's headscarf and blames the physician for her attitude as a woman with a headscarf.

This situation veiled physicians get involved stems from patients' certain expectations from a physician with a headscarf. When a physician wears a headscarf, patients think this physician should have a specific behavior pattern. She should be more tolerable, show more mercy, or favor patients at the expense of others, even it is unfair. This set of expectations put physicians with headscarves under challenging situations.

When it comes to the impact of the abolition of the headscarf ban on female public employment, participants stated various opinions. Since they are insiders, their observations are valuable. Accordingly, there are 5 groups of veiled women who might have increased the female public employment: physicians who came from the private sector, physicians who returned from abroad, physicians who returned to medical education through amnesty, physicians who graduated but stayed at home, and veiled students who entered the medical school after the abolition of the ban and became

physicians. Among all, veiled students who started medical school after the abolition of the headscarf ban comprise the most significant portion of veiled women in public employment. There were veiled women unveiled at work, but they did not increase the female employment rates since they were already in public employment. Although it is difficult to achieve, some veiled physicians returned to medical school through amnesty and women who started working as physicians after staying at home during the ban. However, they are few in numbers.

Considering these findings, I think that female public employment has not been substantially changed with the abolition of the headscarf ban. However, the proportion of veiled women in employment has increased, for sure.

These research findings above have significant implications for understanding how the headscarf affects veiled women's work experiences in the public health sector. In the light of these findings, I argue that even in the seventh year of headscarf freedom, the intersection of gender and religious beliefs put women physicians in challenging positions in the medical workplace. More time is needed to erase the negative impact of the years-long ban and stop the headscarf from being an issue.

On the other hand, women physicians with headscarves seem to have integrated with the public medical workplace. They get along with their colleagues, allied health personnel, and patients. Today, they do not have any headscarf-related problems which might seriously affect their work performance. Participants attribute their comfort with the headscarf to their workplace selections. In other words, they chose hospitals in which they might not expose to discrimination of professors and which has a patient profile in good agreement with the headscarf. The only group that discriminates against veiled physicians for their headscarves is medical professors, who hold higher medical hierarchy positions. However, the prior headscarf ban's repercussions still cause problems for veiled physicians in the medical workplace.

Setting Acker’s (2006) inequality regimes as my conceptual framework for analysis, I found that the medical workplace's organizational structure based on medical hierarchy legitimizes inequalities based on gender and the headscarf. Organizational control based on seniority through the medical hierarchy is internalized by medical

personnel. Consequently, any kind of discrimination such as headscarf-based discrimination becomes challenging to be noticed, thus, to be contended with.

In line with Acker's (2006) concept of visibility of inequalities, I observed that veiled physicians who experienced the headscarf ban, especially during the February 28 process, have severe traumas and are more sensitive in recognizing the headscarf-based discrimination. On the other hand, for veiled physicians who did not encounter discrimination based on the headscarf, headscarf-based discrimination is invisible. These women do not consider the problems they face in the workplace related to the headscarf and attribute the discrimination they face to other conditions.

In this connection, neither the current government in power nor the seven years of headscarf freedom could not help veiled physicians to relieve in terms of their rights to wear a headscarf in education and at work. Medical professors' viewpoints on the headscarf issue and the specific role physicians occupy since the modern nation state-building process as guides of society in social and political issues cause a particular perception of headscarf to prevail. In this kind of setting, veiled physicians could not overcome the fear of returning the ban one day.

One of the significant findings of this thesis is the difference between veiled physicians who went through the February 28 process during work and those who did not. By dividing participants into two groups according to their spent years in the profession, I observed that the February 28 process's impact is evident on several issues constituting the core of veiled women's medical workplace experiences. For instance, these two groups of women have different motivations for choosing medicine and medical specialty. While the former group mainly put religious values to the center while choosing a profession such as serving the society, the latter made their professional choices based on their university entrance exam scores and the like. The medical specialty preferences of these two groups also differ. Formerly, veiled physicians preferred residencies known for their suitability for women: pediatrics, and obstetrics and gynecology. However, veiled women who entered the medical profession maximum of 10 years ago have different motivations in choosing residencies, such as TUS score and medical specialties' features and requirements.

Another difference between these two groups that I found is their attachment to their profession. Veiled physicians who experienced the February 28 process during work had more difficulties. The ones who insisted on working with headscarves were sent to peripheral health institutions, gave up their medical profession careers, and abandoned higher academic and administrative positions. They kept working despite the risk of official interrogation, penalties, and probable discharge. What is more, they regarded working in a peripheral workplace, mostly below their expertise, as an advantage as it allowed working. They were passionate about their profession. On the other hand, veiled physicians who have spent up to ten years in a profession are less motivated than the first group. Veiled physicians are fed up with their problems due to the changing health policies and heavy working conditions.

On the other hand, these two groups of women have commonalities in their work strategies. To minimize the discrimination based on the headscarf and to be noticed by medical professors, veiled physicians of all generations adopted working hard as a strategy. By studying and working hard, they tried to give no space to any kind of mobbing. Besides, these two groups both experienced the headscarf ban. Veiled physicians who were exposed to the headscarf ban still have traumas remaining from the times of the headscarf ban. In this connection, the more they resisted the ban, the more they are sensitive about it.

Nevertheless, the women who have spent up to both thirty years and ten years are united under the medical profession. Although I divided the participants into two groups, the headscarf ban affected all women with headscarves. Furthermore, both groups referred to the veiled physicians who did not experience any headscarf ban as different from themselves. The meaning of the headscarf has changed in time, according to the participants. The headscarf ban, despite its difficulties, provided an identity to veiled women. This identity based on the headscarf helped veiled women to stand firm in the face of injustice. As the headscarf freedom came, veiled women became comfortable and eventually lost this identity, according to the participants, especially those who had up to 30 years in the profession. The attention veiled physicians showed to their profession formerly stemmed from their understanding of being representatives of a particular worldview as veiled women. However, newcomers do not put religious motivations forward while working.

In light of the research findings, I assert that although wearing a headscarf has normalized in the public workplace, the headscarf still is an identity mark. While it influences the in-group positively, the out-group is dissatisfied with seeing veiled physicians in medical workplaces. In this regard, the headscarf is instrumentalized. It has diverse functions in the medical workplace. While the headscarf causes discrimination in some cases, it facilitates relations in others. For instance, veiled physicians stated that they are sometimes exposed to positive discrimination due to their headscarves. Of course, this kind of discrimination is directed from in-group members, who are mostly patients.

Therefore, I argue that the headscarf is an identity mark that deepens gender inequality at the workplace and reduces the adverse effects of gender inequality at the same time. Being a woman in the workplace has its own difficulties. The headscarf exacerbates the effects of gender inequalities. However, it also ameliorates the challenging state of women at work. In such an intricate work with a significant employment volume, higher division of labor, and specialization, the multilayered meanings and the effects of the headscarf are inevitable.

Nevertheless, veiled physicians have difficulties in the medical workplace also due to their gender. At this point, the headscarf has no impact. In line with Acker's (2006) arguments, I found that since medical work's general requirements are set by taking a white man who could dedicate himself to his job and has no other responsibilities such as home and family as the main component of medical work, women physicians have difficulties complying with the working conditions of medical work. Women are disadvantageous in medical work due to gender discrimination and responsibilities at home. Patients are prone to exert violence on women physicians. Additionally, women physicians are usually mistaken for nurses, and in other cases, they are called "Mr. physician".

Women physicians with headscarves have mixed feelings about their current state in the public workplace. During the interviews, they had two different moods. While narrating their experiences during the headscarf ban, they were frustrated and upset. On the other hand, they are content with their situation as working veiled women now, although they still struggle with workplace challenges based on gender and headscarf.

Nevertheless, veiled physicians try to overcome these problems to perform their profession. However, some participants are tired of still fighting for their rights as women with headscarves.

In conclusion, both the headscarf's meanings and the health sector's working conditions have been changing consistently. Therefore, the experiences of veiled physicians in the public medical workplace have also been changing and transforming. Although the negative impact of the previous headscarf ban and the headscarf itself has decreased within years, the impact of gender has been increasing. This implicitly affects the headscarf issue as well. Therefore, the headscarf issue does not seem to cease to be an issue anytime soon. Considering women physicians' state in the medical profession, veiled women physicians seem to continue struggling for their rights as women with headscarves.

The literature on Muslim women in the health sector includes diverse experiences regarding the headscarf based on the country's social, political, and cultural context. The health system, tradition, and religious beliefs in a country also affect veiled women's health sector experiences. Nevertheless, veiled Muslim women face individual discrimination based on gender and religion in every context. While the discrimination stems from the political atmosphere and in some cases labels veiled women as terrorists in a non-Muslim community, this discrimination sometimes results from patriarchal institutional norms and religious beliefs in a Muslim country.

Considering the research findings within the context of the literature on Muslim women with headscarves in the health sector, it can be said that this study coincides with the literature while at the same time adding a new dimension to it by discussing the issue within the Turkish context, which has a multilayered social and political structure. Besides, this thesis discusses women physicians' state with headscarves in the medical workplace both during the headscarf ban and freedom of headscarf.

On the other hand, the state of women physicians in the medical workplace has been studied by scholars from different disciplines (Riska, 2001; Kilminster et al., 2007; Serrano, 2007; Roter & Hall, 1998; Roth et al., 2016; More, Fee & Parry, 2008; Kuhlmann & Annandale, 2012). The gender gap, medical residency, discrimination based on gender, social hierarchies based on gender, the social organization of

medicine and its division of labor, physician-patient relationship, professional status and power, organizational justice, gendered substructure at healthcare workplace are among topics of discussion in the literature. They mainly argue that women mainly work in niches of the health care system or medical specialties characterized by relatively low earnings or prestige.

In this regard, the problems veiled physicians face in the medical workplace as women correspond with the literature on women in medicine. Veiled physicians are exposed to the violence of patients and their relatives more compared to their male colleagues. Veiled physicians are mistaken for nurses most of the time, even when they wear an apron. Additionally, since they get pregnant and take maternity leave, women physicians are not mostly welcomed by medical authorities. Finally, there is a glass ceiling that obstructs their career development in the academy. However, the impact of the headscarf is missing in this literature. This study fills this gap.

In the Turkish context, although the factors hampering women's labor force participation have been studied widely (Aycan, 2004; Pınar et al., 2007; Kardam & Toksöz, 2004; Toksöz, 2011; Beşpınar, 2010; Buğra &Yakut-Çakar, 2010; Göksel, 2013; İlkkaraca, 2012; Özar & Günlük-Şenesen, 1998), the impact of the headscarf had often been neglected. Besides, women with headscarves and work have been studied diversely in Turkish literature. These studies mostly focused on veiled women in low-status jobs, clerical jobs in more conservative companies, or the public offices of Justice and Development Party (*Adalet ve Kalkınma Partisi*, JDP) municipalities (Cindoğlu, 2011; Sayan-Cengiz, 2016; Jelen, 2011; Karaca, 2013; Güveli, 2011) but did not point out the public employment after the abolition of the headscarf ban.

In this regard, this thesis distinguishes itself from previous research on the headscarf issue by examining the role of the headscarf in the public work life of a female physician with headscarf assessing the period after the abolition of the headscarf ban and considering the experiences during the headscarf ban as well. Besides, studying the women with headscarves and work subject with a focus on female professionals with headscarves in public employment is a novel contribution to the literature since women with headscarves in public employment have not been studied to date.

Additionally, the literature on the state of women physicians in Turkey has not pointed out the headscarf as a challenge in the gendered medical workplace while examining the challenges women physicians face in the medical workplace (Genç-Kuzuca, 2007; Bayrakçeken-Tüzel, 2004; Yapıcı et al., 2010, Bekata-Mardin et al., 2000). In this connection, this thesis appears to be the first study to analyze veiled women physicians' experiences to present the headscarf as one of the factors posing a challenge in the medical workplace.

This research has thrown up many questions in need of further investigation. Further studies need to be carried out to understand the implications of these research findings better. Further studies could explore veiled women physicians' experiences in public health institutions who have not faced any headscarf ban during their education and work lives. In that way, the impact of the prior headscarf ban and the headscarf could be observed better. By examining this, further studies could also reveal the time required to eradicate the negative impacts of the years-long headscarf ban on veiled women in education and the workforce.

Besides, further studies might focus on the workplace experiences of women physicians without headscarves and the challenges they face from a sociological perspective. Therefore, the specific position that the headscarf put veiled physicians into could be grasped comprehensively to confirm the findings of this thesis.

The state of veiled women professionals at the workplace and their headscarf-related experiences are also critical. Professional work is a specific type of work and has its own workplace dynamics, which might restrain inequalities at work. However, discrimination based on gender and the headscarf is still widespread in professional work. In this connection, future research could investigate the impact of the headscarf and the previous ban on veiled women professionals' work lives such as engineers, attorneys, and the like. Thus, the medical workplace's specific state and other professional workplace dynamics affecting headscarf discrimination could be addressed.

The last suggestion for future studies is to examine women physicians' workplace experiences other than the headscarf. Due to the difficult studying and working conditions of the medical profession and the medical hierarchy underpinning the

medical work, women physicians have complex experiences. On the one hand, they are in demand and respected. On the other hand, they face particular discrimination based on gender despite their higher professional position. Uncovering this intermingled set of dynamics of the medical profession could be an important contribution to the literature.

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APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
www.ueam.metu.edu.tr

Sayı: 28620816 / 073

20 Şubat 2020

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof.Dr.Ayşe SAKTANBER

Danışmanlığını yaptığınız **Ayşe Sena KÖŞGER'in "İstihdamda Ortaya Çıkan Eşitsizlikler: Ankara Devlet Hastanelerinde Başörtülü Hekimlerin Deneyimleri"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **073-ODTU-2020** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof.Dr. Mine MISIRLISOY
Başkan

Prof. Dr. Tolga CAN
Üye

Doç.Dr. Pınar KAYGAN
Üye

Dr. Öğr. Üyesi Ali Emre TURGUT
Üye

Dr. Öğr. Üyesi Şerife SEVİNÇ
Üye

Dr. Öğr. Üyesi Müge GÜNDÜZ
Üye

Dr. Öğr. Üyesi Süreyya Özcan KABASAKAL
Üye

B. INTERVIEW QUESTIONAIRE

Giriş

1. Kaç yaşındasınız?
2. Hangi okullardan mezunsunuz? (lise ve üniversite)
3. Mesleğiniz nedir? (Uzman hekim/ Asistan/Pratisyen)
4. Uzmanlık alanınız nedir?
5. Kaç yıldır çalışıyorsunuz?
6. Anne-babanız çalışıyor mu?
7. Evli misiniz? Evliyseniz eşiniz ne iş yapıyor?

Başörtüsü Yasağı

1. Ne zaman ve nasıl örtünme kararı aldınız?
2. Hayatınızın bir döneminde başörtüsü yasağıyla karşılaştınız mı? Karşılaştıysanız ne yaptınız?
3. Başörtüsü yasağı sizi nasıl etkiledi?
4. Başörtüsü yasağının kalkmasını nasıl değerlendiriyorsunuz?
5. Sizce yasak kalktıktan sonra neler değişti?
6. Yasak kalktıktan sonra kamuda, özellikle hastanelerde kadın istihdamının arttığını düşünüyor musunuz?
7. Yasak kalkmasaydı da mesleğinizi yapar mıydınız? Yapsaydınız nerede ve nasıl olurdu?

Doktorluk

1. Doktor olmaya ne zaman ve nasıl karar verdiniz?
2. Sizi bu konuda teşvik eden, size yol gösteren oldu mu?
3. Ailenizde başka doktor var mı?
4. Meslekte uzmanlık alanınızı nasıl seçtiniz?
5. Mesleğinizden ve uzmanlık alanınızdan memnun musunuz?
6. Sizce başarılı bir doktor olmak için kişisel olarak sahip olunması gereken nitelikler nelerdir?

Hastane

1. Kamuda çalışmaya nasıl karar verdiniz? Neden devlet hastanesinde çalışmayı seçtiniz?
2. Devlet hastanesiyle diğer sağlık kurumlarının (özel hastane, aile hekimliği vb) farkı nedir?
3. Devlet hastanesinde çalışmanın avantajları ve dezavantajları nelerdir?
4. Biriminizde ve hastanenizde kadın doktor sayısı mı fazla, erkek doktor sayısı mı?
5. Sizce kadın ve erkek doktorların özellikle tercih ettiği/yöneldiği uzmanlık alanları var mıdır? Neden?
6. Ekip halinde mi çalışıyorsunuz? Öyleyse çalışma arkadaşlarınızla nasıl bir iş bölümü yapıyorsunuz? (diğer doktorlar, hemşireler)
7. Burada sosyal yahut yapısal bir hiyerarşiden söz edebilir miyiz?
8. Diğer doktorlarla ilişkinizi nasıl değerlendirirsiniz?
9. Hemşirelerle ilişkinizi nasıl değerlendirirsiniz?
10. Yöneticilerinizle ilişkinizi nasıl değerlendirirsiniz?
11. Hastalarla ilişkinizi nasıl değerlendirirsiniz?
12. Bu gruplardan hangisiyle çalışmak sizin için daha zor? Neden?
13. Bütün bu ilişkilerde başörtüsünün bir etkisi olduğunu düşünüyor musunuz?
14. Başörtülü olduğunuz için herhangi farklı bir muameleyle karşılaştığınızı düşünüyor musunuz?
15. Çalışma hayatınızda kadın olduğunuz için herhangi farklı bir muameleyle karşılaştığınızı/ ayrımcılığa uğradığınızı düşünüyor musunuz? Düşünüyorsanız bunlar nelerdir?
16. Kadın doktorlara eğitim, kariyer ve terfi konularında eşit davranıldığını düşünüyor musunuz? Peki başörtülü doktorlara?

C. TURKISH SUMMARY / TÜRKÇE ÖZET

Başörtüsü, geç Osmanlı ve erken cumhuriyet dönemlerindeki modernleşme çalışmalarıyla bir sorun haline gelmiş, takip eden süreçte de sosyal ve politik atmosfer bu sorunu büyütmüştür. 1980lerde ilk başörtüsü yasağıyla bu sorun resmiyet kazanmıştır. Yasak süresince başörtülü kadınların eğitim hakkı ellerinden alınmış, üniversite kapılarında girememiş ve kamu kurumlarında çalışamamışlardır. Buna ek olarak, yasağın yankıları özel sektörde de kendini göstermiş ve başörtülü kadınlar çalışma hayatında dezavantajlı konuma düşmüştür. AK Parti'nin iktidar olmasıyla yasağın kalkacağına dair umutlar artmış, fakat parti, 2010lara kadar bu konuda ciddi bir adım atmamıştır. 2010 yılında başörtüsü yasağı üniversitelerde, 2013 yılında ise kamuda kalkmıştır. O tarihten beri, başörtülü kadınlar özgürce eğitim alabilmekte ve kamu kurumlarında çalışabilmektedirler.

Türkiye'de kamu kurumlarında başörtüsü yasağının kaldırılmasının üzerinden yedi yıl geçti. Başörtülü kadınların artık başörtüsü sorunu yaşamadıkları düşünülebilir. Ancak, başörtülü kadınlarla kamusal alanın uzlaşması, 30 yıl süren yasak göz önüne alındığında o kadar kolay olmamıştır. Hem başörtülü kadınlar hem de başörtüsü yasağı savunucuları için bir uyum dönemi gerekmektedir. Başörtüsü yasağının kaldırılmasından önce ve sonra, kamu istihdamında başörtülü kadınların varlığı Türk toplumunda yaygın olarak tartışıldı. Bazıları konuyu laik bir bakış açısıyla ele alırken, diğerleri bu kadınların mesleki yeterliliğini sorguladı. Genellikle başörtülü kadınların dini inançlarına göre hareket edecekleri ve bunun sonunda mesleki performanslarını engelleyeceği iddia edilmiştir.

Buna ek olarak, cinsiyet ayrımcılığı ile birlikte kamu kurumlarında başörtülü çalışan kadınlar başörtüsüne dayalı ayrımcılığa maruz kalmaktadır. Yıllardır süren başörtüsü yasağının olumsuz etkisi kısa sürede ortadan kalkmayacak gibi görünmektedir. İşyerinde cinsiyet ayrımcılığı, benzer sosyo-ekonomik geçmişlere sahip hem başörtülü hem de başı açık kadınları taciz etmektedir. Ancak, Cindoğlu'nun da belirttiği gibi, başörtülü profesyonel kadınların karşılaştıkları ayrımcılığın en büyük nedeni

başörtüsüdür (2011, s.5-6). Başörtüsü yasağıyla birleştiğinde, bu ayrımcılık başörtülü kadınları toplumda daha düşük sosyo-ekonomik statüye itmektedir.

Öte yandan, başörtüsü yasağının kaldırılması, laiklik ile İslam arasında uzun süredir devam eden anlaşmazlığın çözümü ve başörtülü kadınların eğitim ve istihdam haklarının geri verilmesinin bir yolu olarak görüldü. Ancak kamu kurumlarında yıllardır süren başörtüsü yasağının etkilerinin ne ölçüde ve nasıl ortadan kaldırıldığı, özellikle bu yasaktan etkilenen kadınlar için sorulması gereken bir soru.

Bu bağlamda bu tez, başörtüsü yasağının kaldırılmasının ardından Türkiye'deki kamu sağlık kurumlarında başörtülü Müslüman kadın hekimlerin deneyimlerini incelemeyi amaçlamıştır. Bu tezin temel araştırma sorusunu, "Başörtüsü meselesi, başörtüsü yasağının kaldırılmasının ardından kamu sağlık sektöründe başörtülü kadın hekimlerin deneyimlerini nasıl şekillendirdi?"dir. Ayrıca başörtülü kadın hekimlerin kamusal işyeri deneyimlerini inceleyerek, tez boyunca şu alt sorulara da cevap vermek amaçlanmıştır: Başörtüsü, başörtülü kadın hekimlerin çalışma hayatını nasıl ve ne şekilde etkiliyor? Önceki başörtüsü yasağı başörtülü kadın hekimlerin çalışma hayatını nasıl ve ne ölçüde etkiliyor? Örneğin, başörtülü hekimlerin mesleklerini, uzmanlık alanlarını, iş yerlerini seçme kararlarını etkiliyor mu? Başörtülü hekimler, kariyerlerinin farklı aşamalarında ilerlemenin önündeki hangi spesifik açık ve örtük engelleri tanımlarlar?

Bu araştırma, bu sorulara cevap arayarak, başörtüsünün hekimlerin çalışma hayatını nasıl şekillendirdiği ve etkilediği hakkında bilgi verir; başörtüsünün hekim-hekim, hekim-yönetici, hekim-yardımcı sağlık çalışanları ve hekim-hasta ilişkileri dahil olmak üzere sağlık sektörü içindeki ilişkileri etkilemedeki rolünü gözlemler; başörtülü hekimlerin farklı branşlardaki istihdam kararlarını etkileyen faktörler hakkında fikir verir. Cinsiyet, sınıf ve dini kimliğin kesiştiği hiyerarşik kamu işyerlerinde çalışan kadınlar olarak başörtüsünün iş hayatındaki rolleri ve anlamları henüz Türkiye'de keşfedilmedi. Bu tez, orta sınıf, üniversite eğitimli kadınlara, başörtülü kadınların işyeri deneyimlerini ve işyerine uyum sürecini ortaya çıkarmak için odaklanmaktadır. Bu amaçla, gözlem birimi olarak başörtülü kadın hekimler seçilmiştir.

Bu çalışma kapsamında farklı literatürler taranmıştır. Hekimler profesyonel çalışmanın bir parçası oldukları için profesyonel çalışma türü ve kadınların

karşılaştıkları zorluklar araştırılmıştır. Sonrasında başörtüsünün iş ilişkilerine etkisini tespit etmek için Türkiye'de başörtülü kadınların işyeri deneyimlerine dikkat çekilmiştir. İkinci kısımda kadın hekimlerin sağlık sektöründeki özel konumlarına odaklanılmıştır. Kadın hekimlerle ilgili literatür, esas olarak tıbbi işyerinin cinsiyetlendirilmiş doğasını ve kadın hekimlerin karşılaştığı ilgili zorlukları tartışmaktadır. Benzer şekilde, Türkiye'deki kadın hekimlerin durumuna ilişkin literatür de cinsiyet ayrımcılığına odaklanmaktadır. Ancak Türkiye'de tıbbi işyerlerinde başörtülü hekimler alanında yapılmış bir çalışma bulunmamaktadır. Bu nedenle Türkiye'deki başörtülü hekimlerin deneyimlerini daha iyi kavramak için dünya sağlık sektöründe başörtülü kadın literatürüne değinilmiştir.

Türkiye'de kadınların işgücüne katılımının temel belirleyicisi eğitim olarak belirtilmektedir. Eğitim seviyesi yükseldikçe kadınların işgücü piyasasına katılım olasılığı artmaktadır. Eğitim düzeyi, prestij ve yüksek ücretler, profesyonel kadınların çalışma özelliklerine örnektir. Her sektörden kadınların işle ilgili sorunları olmasına rağmen, profesyonel kadınlar farklı türde bir işyeri ayrımcılığıyla karşı karşıyadır. Başörtülü kadın hekimlerin eğitimsel ve mesleki yaşamları ile yüksek oranda bağlantılı olduğu için, bu tezde meslek sosyolojisi literatürüne değinilmesi esastır. Kamu sektörünün işgücü özelliği, toplam işgücünden farklıdır. Örneğin, Türkiye'de yüksek öğrenim görmüş kadınların çoğu, profesyonel olarak kamu sektöründe istihdam edilmiştir. Bununla birlikte, eğitim geçmişlerine rağmen, kamu sektöründeki kadınlar zorluklarla karşı karşıyadır. Cinsiyet dışlama iki şekilde gerçekleşir. Birincisi, işi çevreleyen gayri resmi ilişkiler gibi örgütsel kültürler kadınları bir kenara bırakır. İşyerindeki sosyal ağlar, mesleki bilgi bu ağlar aracılığıyla dolaştığı için sayısız avantaj sağlar. Kadınlar çoğunlukla bu bağlantılardan dışlanır ve bu nedenle işyerinde başarı getirebilecek ek bilgi akışından yoksundurlar. İkinci olarak, cinsiyet önyargısı kadınları işyerinde icat edilen beceri bölüşümü yoluyla ayırır. Buna göre erkekler teknik ve nesnel becerilere sahipken, kadınlar sosyal olarak inşa edilmiş becerilere sahiptir. İş deneyimleri becerilerine göre belirlenir ve bu da genellikle kadınları işyerinde dışarıda bırakır.

Başörtülü Müslüman kadınlarla ilgili sağlam bir literatür bulunmasına rağmen, önceki başörtüsü yasağının işgücündeki kadınlar üzerindeki etkisi sadece birkaç araştırmacı tarafından analiz edilmiştir. Güveli (2011), Türkiye'de başörtüsü yasağının kadınların

sosyal ve ekonomik koşullarını nasıl ve ne ölçüde etkilediğini araştırmaktadır. Jelen (2011), üniversite eğitimi almış, üst-orta sınıf kadınların üniversitelerdeki ve profesyonel yaşamdaki deneyimlerini ve isteklerini incelemektedir. Cindoğlu (2011) başörtüsü yasağını kamu ve özel sektör istihdamı üzerindeki etkileri üzerinden incelemektedir. Karaca (2013), işçi-işveren ilişkisine odaklanarak başörtüsü yasağının iş hayatına etkisini incelemektedir. Sayan-Cengiz (2016) Türkiye'de özel sektörde çalışan alt orta sınıf, üniversite eğitimi olmayan kadınlar arasında başörtüsünün müzakere edilen anlamlarını derinlemesine analiz etmektedir. İş yerinde başörtülü kadınlarla ilgili bu çalışmaların başörtüsü yasağının yürürlükte olduğu dönemde yapıldığı belirtilmelidir. Yasağın kaldırılmasının ardından araştırmasını yalnızca Sayan-Cengiz (2016) gerçekleştirdi. Ancak, çalışmasının odak noktası özel sektördür. Dolayısıyla bildiğimiz kadarıyla başörtüsü yasağının kaldırılmasının ardından kamu sektöründe başörtülü kadınların durumunu araştıran bir araştırma daha yoktur.

Tıpta kadınlarla ilgili sosyolojik literatür esas olarak kadınların cinsiyetlendirilmiş sağlık hizmetleri işyerinde profesyoneller olarak konumuna odaklanmaktadır. Kadın hekim yüzdesindeki artışa rağmen, meslek içindeki ayrımcı uygulamalar, cinsiyet ayrımı ve yapısal engeller kadınları dezavantajlı konumlara sokmaya devam ediyor. Kadınların tıpta kariyerlerine ilişkin tartışmalar, kadınların esas olarak, görece düşük kazanç veya prestij ile karakterize edilen sağlık hizmetleri sistemi veya tıbbi uzmanlık alanlarında çalıştıkları argümanı etrafında toplanıyor. Bir çok araştırma, kadın ve erkek hekimlerin cinsiyetle ilgili sorumluluklarına ve özelliklerine göre farklı uzmanlık seçeneklerine sahip olduğunu ortaya koymaktadır. Kadın ve erkek hekimler benzer tıp bilgisine ve akademik performans düzeylerine sahip olsalar da iletişim kalıpları ve uygulama stilleri farklılık göstermektedir. Kadın hekimlere olan talep, tıbbi işyerindeki kadın hekimlerin durumunu da etkilemektedir. Toplumsal gelenek ve dini inançların önemli rol oynadığı toplumlarda kadınlar özellikle özel muayenelerde aynı cinsiyetten hekimleri tercih etmektedir. Tıbbi işyerinde cinsel taciz ve cinsiyet ayrımcılığı yaygındır. Literatüre göre, cinsiyet önyargısı ve cinsel taciz, kadın hekimlerin tam potansiyellerine ulaşmasını engelleyen başlıca engellerdir. Mobbing, sağlık çalışanlarının fiziksel ve ruhsal sağlığı için ciddi bir tehdittir ve kadın sayısının çokluğu nedeniyle sağlık sektöründe çok sık görülmektedir.

Tıpta uzmanlaşma sırasında cinsiyet ayrımcılığı Türkiye bağlamında tartışılırken TUS vurgulanmalıdır. Burada ilginç olan, TUS'un 1987 yılında yürürlüğe girmiş olmasıdır. Bu tarihten önce her fakülte kendi sözlü ve yazılı sınavlarını yapmıştır. Genç-Kuzuca'ya (2007) göre sınav sonuçlarının geçerliliğini kontrol edecek bir mekanizma yoktur. Bu nedenle, ayrımcı kararlar, bazı öğrencilerin o alanda uzmanlaşmasını engeller. TUS sayesinde kadın hekimlere yönelik ayrımcılığın bir ölçüde önüne geçilmektedir. TUS dışındaki mekanizmalar, kadın hekimleri "kadınlara uygun" uzmanlık alanları seçmeye itmektedir. Tıp profesörlerinin ve aile üyelerinin rehberliği ve erkek meslektaşların tutumları bu mekanizmaların bazı örnekleridir. Ayrıca, iş ve aile dengesini korumak, kadın doktorlar için bir uzmanlık seçerken merkezi bir motivasyon kaynağıdır. Çoğunlukla, daha az iş yükü ile daha az yorucu uzmanlıkları tercih ederler. Genel olarak, kadınlar meslektaşlarından, profesörlerinden, yardımcı sağlık çalışanlarından ve hastalarından farklı şekillerde farklı aşamalarda cinsiyete dayalı ayrımcılığa maruz kalmaktadır. Tıpta uzmanlık, statü, ücret ve rekabette cinsiyet eşitsizliğini gözlemlenmektedir.

Tıptan sosyolojiye kadar çeşitli disiplinler başörtülü kadın hekimlerin durumunu incelemiştir. İşyerinde ayrımcılığa ilişkin araştırmalar öncelikle cinsiyet ve ırk üzerine odaklanmış, çok azı dinin ayrımcılık üzerindeki etkisini analiz etmiştir. İslâm nedeniyle işyeri ayrımcılığı, Amerika Birleşik Devletleri'nde özellikle 11 Eylül sonrası Batı bağlamında Müslüman hekimlik kavramı içinde yaygın olarak incelenmiştir çünkü Amerikalı Müslümanlar önemli ölçüde önyargı ve ayrımcılıkla karşı karşıya kalmaya başlamıştır. Öte yandan, birçok çalışma konuyu İslami bağlamda tartışmakta ve genel olarak kadınların işyerinde karşılaştığı ayrımcılığı inceleyen çalışmaların yanı sıra İslami değer ve geleneklerin Müslüman toplumlarda hekimlerin çalışma hayatına etkisini incelemektedir.

Bu çalışmanın odak noktası olarak başörtülü Müslüman kadın hekimlerin seçilmesinin çeşitli nedenleri vardır. Kadınlar, Osmanlı'nın son dönemlerinden itibaren Türkiye'de hekim olmak için mücadele etmişlerdir. İkinci olarak, kamu sağlık sektöründe çalışan kadın sayısı çok yüksektir. Kadın erkek oranı sağlık ve sosyal hizmetler sektöründe en yüksektir. Ayrıca tıp mesleği son derece niteliklidir ve yıllarca eğitim, sıkı çalışma ve özveri gerektirir. Hekimler prestijli pozisyonlara sahiptir. Piyasada her zaman talep gören bir meslektir. Bu nedenle, bu mesleğin kesinlikle nesnel kriterlere ihtiyaç

duyması ve işyerinde ayrımcılığa daha az yer bırakması beklenebilir. Bununla birlikte cinsiyet ayrımcılığı kadınları da sağlık sektöründe zorlu koşullar altında bırakmaktadır. Bunu daha önceki başörtüsü yasağıyla birlikte değerlendirmek, başörtülü kadınların hekimlik haklarını kazanmak için daha çok mücadele etmek zorunda kaldıklarını göstermektedir.

Üniversitede dört yıllık teorik derslerin ardından tıp öğrencileri, hocalarıyla birlikte iki yıl süreyle sahada çalışmak üzere hastanelerde stajyer olarak çalışmaya başlar. Altı yıllık tıp eğitiminin ardından pratisyen hekim olarak mezun olurlar ve çoğunlukla Doğu Anadolu'da olmak üzere kamu sağlık kurumlarında mecburi hizmette bulunurlar. Uzman hekim olabilmek için hekimlerin Tıpta Uzmanlık Sınavına (TUS) girmeleri gerekmektedir. Bundan sonra, profesörlerden eğitim görerek ve hasta muayene ederek bir kamu sağlık kurumunda dört yıllık uzmanlık eğitimi almak zorundadırlar. Ondan sonra tekrar mecburi hizmette bulunmaları gerekmektedir. Hekimler mesleklerinde çalışmak ve ilerlemek için belirli bir süre kamu kurumlarında eğitim görmek ve çalışmak zorundadır. Buna göre Türkiye'de hemen hemen tüm başörtülü kadın hekimlerin eğitim hayatlarında ve çalışma hayatlarında -özel sağlık kurumlarında çalışmayı tercih etmedikleri takdirde- başörtüsü yasağıyla karşı karşıya kalmaları, bu konuyu incelememizin dördüncü nedenini oluşturmaktadır.

Sağlık çalışma alanı, sağlık personeli arasında dinamik ilişkiler kurar. Sağlık hizmeti tesislerinde, özellikle hastanelerde, iş bölümü ve uzmanlaşma en yüksektir. Bu nedenle hekimler her zaman hastalar, hekimler, hemşireler, diğer sağlık personeli ve idari personel ile iletişim halindedir. Hasta bakımı çoğunlukla ekip çalışması gerektirir. Bu nedenle hekimler çoğu zaman gruplar halinde çalışır. Artı, tıbbi uygulama hiyerarşik bir ilişki gerektirir. Tıbbi bakımdan hesap verebilirlik ve sorumluluk paylaşımı için hiyerarşi esastır. Ayrıca, tıbbi bilgi akışı bu hiyerarşiden geçer. Bu hiyerarşi sağlık personelinin kıdem ve mesleki konumuna göre belirlenir. Profesörler tıbbi hiyerarşinin en üstünde yer alırlar. Aşağıda doçentler, uzman hekimler ve asistan hekimler vardır. Öte yandan, yardımcı sağlık personeli tıbbi hiyerarşinin en altında yer almaktadır. Bununla birlikte, mesleki konumlarına ve meslekte geçirdikleri yıllara bağlı olarak, yardımcı sağlık personeli farklı hiyerarşi katmanlarına girebilir. Fakat tıbbi konuların nihai kararı hekimlere ve en kıdemli olanlara bırakılmıştır. Kıdem, tıbbi çalışmanın ana bileşenlerinden biridir. Tıbbi

hiyerarşide kıdem ilişkisi, farklı profesyonel seviyeler arasında ve aynı profesyonel seviye içinde yaygındır. Örneğin, yardımcı hekimlerin uzmanlık eğitimine giriş konusunda kıdem ilişkisi vardır ve uzman hekimler onların kıdemlileridir.

Bu çalışmada, araştırma sorularına cevap aramak için nitel araştırma yöntemlerini kullanılmıştır. İşgücü ve istihdam verileri kadınları başörtülü veya başı açık olarak sınıflandırmadığından, başörtüsü yasağının kaldırılmasının ardından kamuda çalışan kadın sayısındaki değişimi bu araştırmada izlemek için niceliksel araştırma yapmak mümkün olmamıştır. Nitel araştırma yoluyla elde edilen bulgular genellenemese de başörtülü hekimlerin başörtüsü ile ilgili çeşitli deneyimlerini ve karşılaştıkları özgül ayrımcılığın izini sürmemizi sağlıyor.

Araştırma kapsamında 2020 yılı Şubat-Mart ayları arasında, yaklaşık iki ay, kamu sağlık kurumlarında çalışan 21 başörtülü kadın hekimle derinlemesine görüşmeler yapıldı. Görüşmelerde asıl amaç, kadın hekimlerin sağlık sektöründe çalışma bağlamında başörtüsü ile ilgili deneyimlerinin nedenleri, sonuçları ve araçlarını araştırmaktı. Ankara'da kamu sağlık kurumlarında çalışan 21 başörtülü hekimi tespit etmek için kartopu örnekleme tekniğini kullanıldı. İlk katılımcılar, araştırmaya uygun arkadaşlar, akrabalar ve tanıdıklardan bulundu. Böyle bir yaklaşımla birkaç temasa ulaşıldıktan sonra, her bir katılımcı bir başlangıç noktası olacak şekilde kartopu yöntemini kullanıldı. Kartopu örneklemesi, sınırlamalarına rağmen hekimlerin ilişkilerini ortaya çıkarmayı ve alanın ayrıntılı bilgilerine ulaşmayı sağladı. Başörtülü hekimlerin kamu sağlığı kurumlarında yaşadıkları deneyimler, görüş ve beklentiler ile önceki başörtüsü yasağının mevcut durumları üzerindeki etkisi bu araştırma teknikleri ile ortaya çıkarılmaktadır.

Yoğun iş baskısı ve iş yükü nedeniyle hekimlerin programları yoğundur. Bu nedenle görüşmenin yeri ve saati, kendilerini rahat hissetmeleri ve kendilerini verimli bir şekilde ifade edebilmeleri için katılımcılara bırakılmıştır. 21 görüşmeden 3'ü katılımcıların evlerinde, 5'i irtibat kişilerinin özel kliniklerinde, 1'i kamu kurumunda, 2'si aile sağlığı merkezlerinde, kalan 10'u ise Ankara'daki devlet hastanelerinde yapılmıştır. Kaydedilen görüşmelerin deşifre etme süreci mülakat süreci ile eş zamanlı gerçekleşmiştir. Bunu takiben, ana temaları belirlemek için görüşme transkriptlerini analiz edilmiştir. Daha sonra araştırmanın özünü oluşturmak için mülakat

transkriptleri ve saha notları birleştirilmiş ve kamu sağlık kuruluşlarında başörtülü hekimlerin başörtüsü ile ilgili deneyimleri belgelenmiştir. Tezde katılımcılara takma isimler verilmiş, bununla birlikte, analiz bölümünde mülakat alıntılarının yanında katılımcının adı, yaşı ve meslekte geçirdiği yıllar parantez içinde verilmiştir.

Ayrıca 28 Şubat sürecinin etkisini tespit etmek için katılımcılar meslekte geçirdikleri süreye göre ikiye ayrılmışlardır. Birinci grup, iki yıllık mesleki deneyime sahip iki katılımcı ile birlikte meslekte 5-10 yıl geçirmiş hekimlerden oluşmaktadır. İkinci grup meslekte 20-30 yıl geçirmiştir ve diğer bir katılımcı meslekte 32 yıl geçirmiştir. Bu tür bir ayrım, yasağa maruz kalmanın hekimlerin mesleklerine bakış açıları ve meslek anlayışları üzerindeki etkisini ortaya koymuştur. Yasağa ne kadar maruz kalmışlarsa, mesleklerine, insanlarla ilişkilerine ve başörtüsü temelli ayrımcılığa karşı o kadar duyarlı olduklarını varsayılmıştır. Katılımcıların meslekte ortalama geçirdiği yıl sayısı 14'tür. En kıdemli hekim 32 yıldır meslek hayatındadır, en genç hekim ise 2 yılını tıp mesleğinde geçirmiştir.

Bu çalışmada bulgular, Acker'ın (2006) "eşitsizlik rejimleri" teorisinin oluşturduğu kavramsal çerçeve içerisinde incelenmiştir. Çalışma organizasyonlarındaki eşitsizlikleri incelemek için Acker, eşitsizlik rejimleri fikrini ortaya atmıştır. Teori, başörtülü kadınların kamu istihdamına katılımının ve adaptasyonunun analiz edilmesini sağlayan "kesişimsellik" ve "işyeri" ni birleştirmektedir. Eşitsizlik rejimi, cinsiyet, sınıf ve ırka dayalı sistemik eşitsizlikleri sürdüren bir dizi kesişen uygulama, süreç, eylem ve anlam anlamına gelir. Daha önce de belirtildiği gibi, kadın hekimler cinsiyetlerinden dolayı işyerinde görece dezavantajlıdır. İşyerinde kadınların durumu, cinsiyet ve sınıf, ırk ve etnisite gibi diğer eşitsizlik belirteçlerini birleştiren kesişimsellik perspektifiyle analiz edilmiş, din kapsamlı bir şekilde incelenmemiştir. Türkiye bağlamında, başörtüsü meselesi, cinsiyete ek olarak, işte başörtülü kadınların durumunun belirlenmesinde hayati bir role sahiptir. Bu nedenle başörtüsü, bu tez kapsamında eşitsizlik rejiminin bir bileşeni olarak ele alınmıştır.

Çalışma sırasında kamu kurumlarında başörtüsü yasağının kaldırılmasından sonra bile başörtüsünün başörtülü hekimlerin işyeri deneyimlerini etkilediği görülmüştür. Bu etki hem olumsuz hem de olumlu olmaktadır. Önceki başörtüsü yasağı, başörtülü hekimlerin tıp mesleğini, üniversitelerini, tıpta uzmanlık alanlarını ve işyerlerini

seçme kararlarını büyük ölçüde etkilemiştir. Başörtülü hekimler bu kararları başörtüsü yasağından en az etkilenecekleri şekilde almışlardır. Dolayısıyla günümüzde başörtülü hekimler meslek yaşamlarında başörtüsü yasağının izlerini taşımaktadır. Bu tezin araştırma bulgularına dayanarak, başörtülü kadınların hala toplumu tarafından tanınması için çabaladığı ileri sürülmektedir. Başörtülü hekimlerin deneyimleri, önceki başörtüsü yasağının olumsuz etkilerinin tamamen ortadan kaldırılmadığını göstermiştir.

Yasak sırasında başörtülü hekimlerin olumsuz eğitim deneyimlerinin iş performanslarını ve mesleklerine bağlılıklarını etkilediğini görülmüştür. Başörtülü hekimler üniversite kampüslerinde geçirdikleri zamanları kısıtladıkları için zorunlu olmayan derslere veya öğrenci kulüplerinin sosyal veya bilimsel faaliyetlerine katılmadılar. Bu nedenle, profesörleri ve meslektaşları ile gayrı resmi etkileşimlerden yoksundular, bu da bu gayri resmi etkileşimler yoluyla dolaşan tıbbi bilgi alımını azalttı.

Öte yandan, hükümetin sürekli değişen sağlık politikaları nedeniyle hekimlerin çalışma koşulları kötüleşmektedir. Haklarının kapsamı azalmakta ve sorumluluklar artmaktadır. Başörtüsü meselesi tıp mesleğinin zorlu çalışma koşulları ile birleştiğinde başörtülü hekimler, karşılaştıkları işyeri problemleriyle başa çıkacak enerjiyi bulamamaktadır. Eğitimde başörtüsü yasağı sırasında yaşadıkları mücadele, katılımcıların mesleki coşkusunu sarsmaktadır. Ancak elbette bütün başörtülü hekimler için durum böyle değildir. Yıllar süren başörtüsü özgürlüğü mücadelesinin ardından başörtülü hekimler, zorluklara rağmen başörtülü çalışmaktan ve mesleğinden memnundur.

Başörtüsü yasağının kaldırılmasının ardından başörtüsünün başörtülü hekimlerin çalışma hayatına etkileri bir miktar devam etmiştir. Özellikle yasağın kaldırılmasının hemen ardından başörtülü hekimler, tıp profesörlerinden başörtüsü temelli ayrımcılık yaşamışlardır. Başörtülü tıp öğrencileri başörtüsü özgürlüğüne rağmen derslerden atılmış, aşağılanmış ve taciz edilmiştir. Ancak yasak taraftarları ile başörtülü hekimler arasındaki gerilim zaman geçtikçe azalmıştır.

Bu araştırmanın önemli sonuçlarından biri, tıbbi hiyerarşi ile cinsiyete dayalı ayrımcılık ve başörtüsü arasındaki yakın ilişkidir. Katılımcılar başörtüsüyle ilgili

herhangi bir ayrımcılığa maruz kalmadıklarını söyleseler de, konuşmalar devam ettikçe tıp hiyerarşisinin üst kademelerinde bulunanların, özellikle profesörlerin, işyerinde başörtülü hekimlere karşı hala ayrımcılık yaptığı ortaya çıkmıştır. Ancak başörtülü kadınlar, kendi düzeylerinde veya daha düşük seviyede sağlık personelinin başörtüsü temelli ayrımcılığına maruz kalmamaktadır. Bu bağlamda, bu çalışmada tıp hiyerarşisinin başörtüsü temelli ayrımcılığı meşrulaştırarak ve tıp profesörlerinin başörtüsüne karşı sosyal ve siyasi görüşlerini hayata geçirmelerini sağlayarak başörtülü hekimleri olumsuz etkilediği ortaya konmuştur.

Öte yandan tıp profesörlerinin tutumları sadece tıp hiyerarşisindeki daha yüksek konumlarından kaynaklanmamakta, modernleşme, laiklik ve bilim arasındaki güçlü bağ, tıp profesörlerinin başörtüsü hakkındaki bakış açılarının belirlenmesinde de önemli bir rol oynamaktadır. Bu bağlantı, tıp profesörlerinin entelektüel bir elit haline geldiği ve modernizasyon projesine rehberlik ettiği Osmanlı son ve erken cumhuriyet döneminin modernleşme dönemine kadar uzanmaktadır. Bu anlayış bir oranda devam etmekte ve hekimler kendi siyasi görüşlerini yaşadıkları topluma yöneltme yetkisi vermektedir. Laiklik ve bilim, modernleşmenin temel unsurları arasında sayılmaktadır. Dolayısıyla ileri bilimin uygulandığı tıbbi işyerinde dinin yeri yoktur. Bu bakımdan bir kadının dini inançlarının simgesi olan İslami başörtüsü tıpla çelişmektedir. Başörtüsü yasağı kaldırılsa da, tıp profesörleri çoğu zaman başörtülü hekim adaylarını hoş karşılamamaktadır. Bu noktada tıp profesörlerinin homojen bir grup olmadığını belirtilmelidir. Başörtüsü yasağını destekleyen ve başörtüsü özgürlüğünü savunan tıp hocaları mevcuttur. Bu nedenle genellemelerden kaçınılmalıdır. Bununla birlikte, tıp mesleğinin kendine özgü doğası ve yukarıda belirtilen nedenlerle başörtüsü sorunu karşısında hekimler, diğer fakülte hocalarından farklı bir konuma sahip olmuştur. Katılımcıların anlatıları bu iddiayı doğrulamaktadır. Katılımcılar, tıp profesörlerinin tıp işyerinde başörtüsüne dayalı ayrımcılık yapan ana grup olduğunu belirtmektedir. Bu bağlamda başörtülü hekimlerin siyasi konjonktür değişirse ve bir gün başörtüsü yasağı uygulanırsa tıp fakültesinin yasağı hoş karşılayan ve uygulayan ilk grup olacağını düşündükleri gözlemlenmiştir. Başörtülü hekimlerin, özellikle 28 Şubat sürecini yaşamış olanların başörtüsü yasağının olumsuz etkilerini aşamadıklarını ve yasağın geri dönüşünden hala korktuklarını ileri sürülmektedir.

Hasta-hekim ilişkileri açısından başörtülü hekimlerin hasta veya hasta yakınları ile başörtüsüyle ilgili herhangi bir sorunu yoktur. Aksine pozitif ayrımcılık yaşadıklarını düşünürler. Başörtülü hekimlerin hastalarla iyi ilişkileri olmasına rağmen, başörtüsü bir noktada devreye girmektedir. Bir hasta sıra beklemek veya tedavi olmak gibi nedenlerle başörtülü bir hekimle tartıştığında, tartışma er ya da geç başörtüsü sorununa dönüşmektedir. Hasta, hekimin başörtüsüne sözlü saldırmakta ve tavrından dolayı başörtülü kadın hekimi suçlamaktadır. Bu durum, hastaların başörtülü bir hekimden belirli beklentileri olmasından kaynaklanmaktadır. Bir hekim başörtüsü taktığında hastalar bu hekimin belirli bir davranış kalıbına sahip olması gerektiğini düşünür. Daha tahammüllü olmalı, daha fazla merhamet göstermeli veya adil olmasa bile başka hastalar pahasına o hastaları tercih etmelidir.

Başörtüsü yasağının kaldırılmasının kadınların kamu istihdamı üzerindeki etkisi söz konusu olduğunda katılımcılar çeşitli görüşler dile getirmişlerdir. Buna göre kadın kamu istihdamını artırabilecek 5 grup başörtülü kadın vardır: özel sektörden gelen hekimler, yurt dışından dönen hekimler, af yoluyla tıp eğitimine dönen hekimler, mezun olduktan sonra evde oturup çalışmayan hekimler ve yasağın kaldırılmasının ardından tıp fakültesine giren ve hekim olan başörtülü öğrenciler. Son grup en önemli bölümü oluşturmaktadır. İş yerinde başörtülü kadınlar vardı, ancak zaten kamuda çalıştıkları için kadın istihdam oranlarını artırmamışlardır. Bu bağlamda, başörtüsü yasağının kaldırılmasıyla birlikte kadın kamu istihdamının büyük ölçüde değişmediğini düşünülmektedir. Ancak, istihdamda başörtülü kadınların oranı elbette artmıştır.

Bu bulgular ışığında, başörtüsü özgürlüğünün yedinci yılında bile cinsiyet ve dini inançların kesişmesinin kadın hekimleri sağlık sektöründe zor durumlara soktuğunu ileri sürülmektedir. Öte yandan başörtülü kadın hekimler, kamu sağlık işyeri ile bütünleşmiş görünmektedir. Meslektaşları, yardımcı sağlık personeli ve hastalarla iyi geçinirler. Günümüzde iş performanslarını ciddi şekilde etkileyebilecek başörtüsü kaynaklı sorunları yoktur. Katılımcılar bu durumu iş yeri seçimlerine bağlamaktadır. Hocalar tarafından ayrımcılığına maruz kalmayacakları ve başörtüsü ile uyumlu hasta profiline sahip hastaneleri tercih etmişlerdir. Başörtüleri nedeniyle başörtülü hekimler aleyhine ayrımcılık yapan tek grup, daha yüksek tıp hiyerarşisi konumunda olan tıp profesörleridir. Bununla birlikte, önceki başörtüsü yasağının yansımaları, başörtülü

hekimler için hala sorun yaratmaktadır. Tıbbi hiyerarşi aracılığıyla kıdeme dayalı örgütsel kontrol, sağlık personeli tarafından içselleştirilir. Sonuç olarak, başörtüsü temelli ayrımcılık gibi her türlü ayrımcılığın farkına varılması ve dolayısıyla üstesinden gelinmesi güçleşmektedir.

Acker'ın (2006) eşitsizliklerin görünürlüğü kavramına paralel olarak, özellikle 28 Şubat sürecinde başörtüsü yasağına maruz kalmış başörtülü hekimlerin ağır travmalar yaşadıkları ve başörtüsü temelli ayrımcılığı tanımada daha duyarlı olduklarını gözlemlenmiştir. Öte yandan başörtüsüne dayalı ayrımcılık ile karşılaşmayan başörtülü hekimler için başörtüsüne dayalı ayrımcılık görünmezdir. Bu kadınlar işyerinde başörtüsü ile ilgili olarak karşılaştıkları sorunları dikkate almamakta ve karşılaştıkları ayrımcılığı başka koşullara bağlamaktadır. Bu bağlamda ne mevcut hükümet ne de yedi yıllık başörtüsü özgürlüğü, başörtülü hekimlerin eğitimde ve işyerinde başörtüsü takma hakları konusunda rahatlamalarına yardımcı olamamıştır. Tıp profesörlerinin başörtüsü meselesine bakış açıları nedeniyle belirli bir başörtüsü algısının hakim olduğu bir ortamda, başörtülü hekimler bir gün yasağın geri dönme korkusunu yenememişlerdir.

Bu tezin önemli bulgularından biri, 28 Şubat sürecinde hekimlik yapan ve yapmayan kadınlar arasındaki farktır. Katılımcılar meslekte geçirdikleri yıllara göre iki gruba ayrıldığında, 28 Şubat sürecinin başörtülü kadınların işyeri deneyimlerinin özünü oluşturan çeşitli konularda belirgin etkisi olduğu gözlemlenmiştir. Örneğin, bu iki grup kadın, hekimliği ve tıp uzmanlığını seçme konusunda farklı motivasyonlara sahiptir. İlk grup mesleği seçerken esas olarak dini değerleri merkeze koyarken ikinci grup mesleki seçimlerini üniversite giriş sınavı puanlarına ve benzerlerine göre yapmışlardır. Bu iki grubun tıpta uzmanlık tercihleri de farklılık göstermektedir. Eskiden başörtülü doktorlar kadınlara uygunluğu ile bilinen uzmanlık alanlarını tercih ederken, diğer grup TUS puanı ve tıbbi uzmanlık özellikleri ve gereksinimleri gibi motivasyonlara sahiptir.

Bu iki grup arasındaki bir diğer fark da mesleklerine olan bağlılıklarıdır. 28 Şubat sürecini işyerinde yaşayan başörtülü hekimler daha da zorlanmıştır. Başörtülü çalışma konusunda ısrar edenler, çevre sağlık kuruluşlarına gönderilmiş, mesleği bırakmış, yüksek akademik ve idari görevlerini terk etmişlerdir. Resmi sorgulama, cezalar ve

muhtemel işten çıkarma riskine rağmen çalışmaya devam etmişlerdir. Öte yandan, ikinci grup ilk gruba göre daha az motivedirler. Değişen sağlık politikaları ve ağır çalışma koşulları nedeniyle başörtülü hekimler sorunlarından bıkmış durumdadırlar. Öte yandan, bu iki kadın grubunun çalışma stratejilerinde ortak yönleri var. Başörtüsüne dayalı ayrımcılığı en aza indirmek ve tıp profesörleri tarafından fark edilmek için tüm kuşakların başörtülü hekimleri, sıkı çalışmayı strateji olarak benimsemiştir.

Bununla birlikte, katılımcıları iki gruba ayrılsa da, başörtüsü yasağı tüm başörtülü kadınları etkiledi. Ayrıca her iki grup da başörtüsü yasağı yaşamayan başörtülü hekimlere kendilerinden farklı olarak tanımlamışlardır. Katılımcılara göre başörtüsünün anlamı zamanla değişti. Başörtüsü yasağı, zorluklarına rağmen başörtülü kadınlara kimlik kazandırdı. Bu kimlik, başörtülü kadınların adaletsizlik karşısında sağlam durmalarına yardımcı oldu. Başörtüsü özgürlüğü geldikçe, özellikle meslekte 30 yıl geçirmiş katılımcılara göre başörtülü kadınlar rahatladı ve sonunda bu kimliğini yitirdi. Örtülü hekimlerin mesleklerine gösterdikleri ilgi, eskiden, belirli bir dünya görüşünün örtülü kadınlar olarak temsilcileri olma anlayışlarından kaynaklanıyordu. Ancak yeni gelenler çalışırken dini motivasyonları öne çıkarmamaktadırlar.

Araştırma bulguları ışığında kamuya açık işyerinde başörtüsü takmanın normalleşmesine rağmen başörtüsünün hala bir kimlik işareti olduğunu ileri sürülmektedir. Bu bakımdan başörtüsü araçsallaştırılmıştır, çalışma hayatında çeşitli işlevleri vardır. Başörtüsü kimi durumlarda ayrımcılığa neden olurken diğerlerinde ilişkileri kolaylaştırmaktadır. Örneğin başörtülü hekimler bazen başörtüleri nedeniyle pozitif ayrımcılığa maruz kaldıklarını belirtmişlerdir. Tabii ki, bu tür ayrımcılık, çoğunlukla hasta olan grup içi üyelerden yönlendirilir. Dolayısıyla başörtüsünün işyerinde cinsiyet eşitsizliğini derinleştiren ve aynı zamanda toplumsal cinsiyet eşitsizliğinin olumsuz etkilerini azaltan bir kimlik işareti olduğunu savunulmaktadır. İşyerinde kadın olmanın kendine göre zorlukları vardır. Başörtüsü bunu derinleştirmektedir. Bununla birlikte, işyerinde kadınların zorlu durumunu da iyileştirir. Önemli bir istihdam hacmi, daha yüksek iş bölümü ve uzmanlık içeren böylesine karmaşık bir işte başörtüsünün çok katmanlı anlamları ve etkileri kaçınılmazdır.

Bununla birlikte başörtülü hekimler, cinsiyetlerinden dolayı da tıbbi işyerinde zorluk yaşamaktadır. Bu noktada başörtüsünün etkisi yoktur. Hekimler sağlık çalışma koşullarına uymakta güçlük çekmektedir. Kadınlar, iş dışı sorumlulukları ve cinsiyet ayrımcılığı nedeniyle tıbbi işlerde dezavantajlıdır. Hastalar kadın hekimlere şiddet uygulama eğilimindedir. Ek olarak, kadın hekimler genellikle hemşirelerle karıştırılırlar yahut "Doktor Bey" diye anılırlar.

Sonuç olarak hem başörtüsünün anlamı hem de sağlık sektörünün çalışma koşulları sürekli olarak değişmektedir. Bu nedenle, kamusal sağlık işyerinde başörtülü hekimlerin deneyimleri de değişmekte ve dönüşmektedir. Yıllar içinde önceki başörtüsü yasağının ve başörtüsünün olumsuz etkisi azalmış olsa da, cinsiyetin etkisi artmaktadır. Bu dolaylı yoldan başörtüsü meselesini de etkiliyor. Dolayısıyla başörtüsü meselesi yakın zamanda sorun olmaktan çıkacak gibi görünmemektedir.

Daha ileri araştırmalar, eğitim ve çalışma hayatları boyunca başörtüsü yasağı ile karşılaşmayan başörtülü kadın hekimlerin kamu sağlığı kurumlarındaki deneyimlerini araştırabilir. Böylelikle önceki başörtüsü yasağının ve başörtüsünün etkisi daha iyi görülebilir ve yasağının eğitimde ve iş gücünde başörtülü kadınlar üzerindeki olumsuz etkilerini ortadan kaldırmak için gereken süreyi de ortaya çıkarabilir. Ayrıca, başörtüsü takmayan kadın hekimlerin işyeri deneyimleri ve karşılaştıkları zorluklar üzerine yapılacak çalışmalara da odaklanılabilir. Dolayısıyla başörtüsünün başörtülü hekimleri içine soktuğu belirli konum kapsamlı bir şekilde kavranabilir.

İş yerinde başörtülü kadın profesyonellerin durumu ve başörtüsü ile ilgili deneyimleri de kritiktir. Bu bağlamda, gelecekteki araştırmalar başörtüsünün ve önceki yasağın mühendisler, avukatlar ve benzeri gibi başörtülü kadın profesyonellerin çalışma hayatları üzerindeki etkisini araştırabilir. Böylelikle, sağlık sektörünün özel durumu ve başörtüsü ayrımcılığını etkileyen diğer mesleki dinamikler ele alınabilir.

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YAZARIN / AUTHOR

Soyadı / Surname : KÖŞGER
Adı / Name : Ayşe Sena
Bölümü / Department : Sosyoloji / Sociology

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