

# **Increasing Female Doctor Representation in Japan: A Public Health Imperative**

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## **Introduction**

Despite the OECD average for female doctors reaching 50%, Japan has a proportion of just 23.6%, one of the lowest in the OECD, alongside Korea (OECD, 2024; Ministry of Health, Labour and Welfare, 2022). This gap does not come from a lack of women wanting to become doctors. Instead, it's the result of systemic obstacles in the healthcare system that make it difficult for women to enter and stay in the medical profession. Five main factors drive these structural problems: chronic doctor shortages, discrimination in medical school entrance exams, harsh work culture and career barriers, and traditional gender role expectations.

The shortage of female doctors is not just about gender equality; it's also a public health issue (Myers and Sutcliffe, 2018). Female doctors make important contributions to public health in three key areas: clinical outcomes and patient safety, preventive care and patient-centred communication, and promoting diversity and cultural change in medicine.

Drawing on international evidence, this study shows how female doctors positively impact public health, examines the structural and cultural barriers preventing their integration, and proposes three policy recommendations to improve health outcomes: structural reforms to address doctor shortages and long working hours, stronger support for flexible career paths and childcare, and efforts to reduce cultural barriers and gender discrimination. Creating a supportive and fair working environment for female doctors is not just a matter of gender equality; it's essential for better public health outcomes.

## **Structural Barriers Preventing Female Doctors from Fully Participating in Medicine**

### ***1. Chronic Doctor Shortages and Harsh Working Conditions***

Japan's healthcare system has faced a chronic shortage of doctors for many years (Yoshida, 2021). This persistent shortage has created harsh working conditions for doctors, making it difficult for female doctors to sustain their careers (Nomura et al., 2015). The doctor shortage imposes long working hours on doctors, and despite work-style reforms implemented in 2024, significant improvements have not been observed (Matsumoto, 2025). A 2020 survey revealed that 20% of physicians work over 80 hours of overtime per month, reaching the threshold for 'karoshi' (death from overwork), according to Matsumoto (2025). Under these conditions of doctor shortage, when female doctors take leave for pregnancy or childcare or are exempted from night shifts, their workload shifts to colleagues, creating workplace tensions and resentment (Nomura et al., 2015; Naito, 2020). However, night shifts and long

working hours during pregnancy carry risks of miscarriage, forcing many female physicians to resign from their positions (Nomura et al., 2015).

## ***2. Discrimination in Medical School Entrance Exam***

One reason why it is difficult for women to become physicians in Japan is gender discrimination in medical school entrance examinations. This issue came to light in 2018 when Tokyo Medical University was found to have intentionally reduced female applicants' entrance exam scores, implementing admission practices disadvantageous to women (Naito, 2021). Similar measures were discovered at other universities as well, according to Naito (2021). This discrimination against women is believed to stem from the perception of women as an unstable workforce due to higher average rates of career interruption for childbirth and childcare, resulting in hesitancy to invest in female doctors under Japan's medical culture that prioritises workforce stability (Naito, 2021). A survey of doctors revealed that over half viewed discrimination against women as either a necessary measure or, while not ideal, a necessary evil (Matsumoto, 2025). The reasons cited included women's tendency to choose fewer demanding specialities and the fact that female doctors who do not take on night shifts or overtime duties are still counted as full doctors, which increases the workload burden on their male colleagues (Yoshida, 2021).

## ***3. Traditional Gender Role Expectations***

The gender division of labour deeply embedded in Japanese society and the medical profession restricts female doctors' career choices under the imposed expectation of 'balancing work and family' (Nomura, 2015). This burden is disproportionately placed on working women (Nomura, 2015). Female doctors are more likely to marry male doctors, but even when their spouses are not doctors, they tend to reduce their working hours to engage in housework and childcare (Naito, 2020). This phenomenon, known as the 'second shift,' compels women to take on an additional burden beyond the already demanding work environment of doctors, as a second workday of domestic responsibilities awaits them after their clinical duties (Matsumoto, 2025). Consequently, female doctors incline toward specialities more compatible with household and childcare responsibilities, contributing to doctor shortages in certain fields such as surgery (Naito, 2022). When the burdens imposed by gender-based division of labour combine with the harsh working conditions in medicine, many women are forced to either leave the profession or transition to part-time positions (Nomura et al., 2015). This is particularly problematic as it often occurs during critical training years, forcing some to stop pursuing specialist certifications and resulting in career stagnation (Nomura et al., 2015; Naito, 2022). Although women face considerable difficulties in entering the medical profession and sustaining their careers, their presence as physicians can have a significant positive impact on public health due to gender-related characteristics.

## **The Impact of Female Doctors on Public Health**

### ***1. Better Clinical Outcomes***

Recent research demonstrates that female doctors achieve better clinical outcomes than their male counterparts. This challenges earlier claims that the influence of physician gender on doctor-patient interactions and clinical quality cannot be definitively established (Weisman and Teitelbaum, 1985). Earlier studies were limited because female physicians were just entering fields like gynaecology, general practice, and internal medicine, and systematic methodologies to examine gender effects on care processes and outcomes had not yet been established (Weisman and Teitelbaum, 1985). Nevertheless, it was already theorised that physician gender might influence patient outcomes through 'communication of information', 'affective tone', and 'negotiative quality' (Weisman and Teitelbaum, 1985).

In recent years, research has advanced with concrete systematic methodologies, and numerous studies have demonstrated that female doctors have a positive influence on patient survival and recovery rates. According to Heybati et al. (2025), patients treated by female physicians in both medical and surgical settings exhibited lower mortality rates compared to those treated by male physicians, with similar results reported by Dacre et al. (2020). Similarly, research cited by Myers and Sutcliffe (2018) examining 1.5 million Medicare patients found that those treated by female doctors had lower rates of mortality and readmission within 30 days.

While various studies have statistically demonstrated that treatment by female doctors is more likely to produce positive patient outcomes, the benefits are particularly pronounced when doctor and patient gender align, especially when female doctors treat female patients (Heybati et al, 2025). Myers and Sutcliffe (2018) highlighted that this mortality difference approximates the mortality improvement achieved through ten years of scientific advancement in patient care.

### ***2. Patient-Centred Communication and Preventive Care***

Female physicians' preventive, patient-centred practice style improves health outcomes and healthcare safety at both individual and population levels. Female physicians' patients are more likely to receive preventive services regardless of gender (Henderson and Weisman, 2001). They provide more gender-specific screening and counselling to female patients, and more counselling on health behaviours and sensitive topics to male patients (Henderson and Weisman, 2001). Patients of female doctors are particularly likely to undergo preventive screenings such as mammograms regularly and report higher satisfaction with these services (Renkas, 2019). Such preventive care practices may explain why female physicians' patients are more likely to achieve better clinical outcomes.

A key factor closely linked to this preventive care approach is the unique communication style employed by female doctors. Female doctors spend an average of 2.24 minutes longer per consultation than male doctors (Jefferson et al., 2013). They tend to take out more biopsychosocial information by encouraging patients to speak, and patients feel more comfortable disclosing information to them (Hall and Roter, 2002). Female doctors are less likely to hold gender stereotypes, viewing women as passive decision-makers or men as inherently stoic and uncommunicative, which enables them to provide female patients with more decision-making opportunities while more actively engaging male patients in information exchange and explanation (Weisman and Teitelbaum, 1985). This patient-centred communication style increases patient satisfaction and treatment adherence, potentially contributing to the better clinical outcomes observed among female physicians' patients (Jansen and Lagro-Janssen, 2012; Heybati, 2025).

### ***3. Promoting Diversity and Cultural Transformation in Medicine***

The increasing presence of female physicians itself may transform traditional medical practices and positively impact public health. Historically, the organisational structure of Western medicine has been masculine, emphasising authority (Temkin et al., 2024). However, as more women enter medical schools, this structure is evolving (Temkin et al., 2024). The rise in female physicians contributes to the feminisation of healthcare, potentially shifting the field toward more patient-centred care (Bertakis, 2009). Patient-centred care embodies traditionally feminine qualities of service-oriented and compassionate communication, which may be more aligned with the fundamental essence of medicine (Temkin, 2024). Research has shown that female physicians score higher in emotional intelligence (EI) than their male counterparts, and EI demonstrates strong correlations with patient satisfaction (Manoharan, Durai, and Rajesh, 2022). Physicians with higher EI communicate more effectively, strengthen both the quality of care and physician-patient communication, and increase patient satisfaction (Manoharan, Durai, and Rajesh, 2022). The broader integration of this feminine communication style into healthcare practice could therefore yield substantial public health benefits. As women continue to enter the medical profession, weakening the gendered associations within medicine and redefining medical culture, all physicians could benefit from it, potentially leading to improved healthcare delivery overall (Hall and Roter, 2002; Temkin, 2024).

Gender discrimination within the Japanese medical community can be said to hinder the positive impact that female physicians could have on public health. As the number of female physicians gradually increases, this has the potential to generate substantial positive effects on public health at a broader scale.

## **Policy Recommendations**

This section analyses policy approaches to addressing structural issues that limit the growth of female physicians in Japanese society.

### ***1. Addressing Doctor Shortages and Long Working Hours***

Long working hours stemming from Japan's chronic doctor shortage drive women to abandon their careers to balance family life. Better working conditions are crucial for both reforming healthcare and boosting women's participation in medicine (Arai et al., 2025). The first step is strict enforcement of the doctor overtime caps (960 or 1,860 hours annually) introduced in April 2024 (Ministry of Health, Labour and Welfare, 2024). Yet Imamura et al.'s (2025) research shows that there has been no significant change on the ground, with some physicians even finding it harder to work, indicating that further reforms are needed. Ueyama (2024) stated that the reason for this is that the Labour Standards Inspection Office tend to take a lenient approach toward regulating medical institutions to preserve regional healthcare services. In addition, proper time management and overtime compensation require increased labour costs and administrative staffing, which can place hospitals at a financial disadvantage (Ueyama, 2024). As a result, medical institutions that refrain from implementing reforms are often in a more favourable economic position, indicating the need for stronger penalties and enforcement mechanisms (Ueyama, 2024). The second measure is implementing a task-sharing system. This involves redistributing tasks currently performed by physicians to other healthcare professionals, such as nurses and pharmacists, thereby reducing the burden on doctors (Okinaga, 2024). By reassessing the medical tasks currently performed by physicians and redistributing some of these responsibilities to other healthcare professionals, it is possible to reduce physicians' workload and potentially decrease long working hours.

### ***2. Strengthening Flexible Career Paths and Childcare Support***

In addition to improving working conditions, flexible work arrangements are necessary to ensure that women can remain in the medical profession without career interruption by life events. First, systems should facilitate short-hour regular employment and reduced working hours (Dacre et al., 2020). Job-sharing arrangements are also effective measures (Dacre et al., 2020). However, under the current system, part-time work often prevents career advancement; thus, solutions to this issue will be presented in a later section. Second, on-site childcare facilities with extended hours should be expanded, and for those who cannot utilise them, financial support for babysitters or housekeeping services should be provided (Arai et al., 2025; Naito, 2020). This prevents female physicians from leaving the workforce due to childcare responsibilities and helps maintain the medical labour force (Arai et al., 2025). Third, arrangements for childbirth and childcare should be integrated into the requirements for

obtaining and renewing specialist certifications (Dacre et al., 2020; Naito, 2020). This would prevent talented women from leaving medicine and enable them to build long-term careers (Naito, 2020).

### ***3. Reducing Cultural Barriers and Gender Discrimination***

However, even if the number of female physicians increases, their working conditions will not improve unless the male-dominated culture within the medical profession itself changes. It is therefore necessary to transform the medical community into a more supportive and inclusive working environment. Canada's case is the one to learn from: despite growing numbers of female physicians, female doctors are experiencing unchanged cultural challenges around work-life balance and pregnancy timing for three decades (Mobilos, Chan, and Brown, 2008). Japan must therefore not only support female physicians but fundamentally reform medicine's male-centred culture (Naito, 2020). This means transitioning physician evaluation and promotion from metrics like long hours and tenure to performance-based criteria emphasising outcomes, contributions, and competence (Dacre et al., 2020). Such shifts would allow doctors to use the reduced hours and flexible employment arrangements, which were mentioned earlier, to progress in their careers without penalty (Dacre et al., 2020). The system would move from valuing workforce continuity to recognising the high-quality care female physicians deliver. Furthermore, gender discrimination embedded in Japan's medical culture should be reduced. Educational programs targeting unconscious bias at the medical school level, combined with structural reforms, would address both cultural attitudes and systematic barriers simultaneously (Arai et al., 2025). Finally, supporting female physicians' career development to increase the number of women in leadership roles will enable them to serve as role models for younger women entering the profession (Dacre et al., 2020; Arai et al., 2025).

### **Conclusion**

Female doctors play an essential role in advancing public health. Their contribution extends beyond individual consultations, improving clinical outcomes, enhancing patient safety, and strengthening preventive care across populations. Moreover, as the proportion of female doctors increases, it accelerates a cultural shift toward more patient-centred, communicative, and emotionally attentive models of care, qualities that research consistently correlates with higher-quality healthcare delivery. However, these benefits cannot be fully realised without addressing the structural and cultural constraints that limit women's participation in medicine. Japan must therefore tackle chronic doctor shortages, excessive working hours, rigid career structures, and insufficient childcare support, all of which disproportionately disadvantage female physicians. At the same time, deeply embedded gender norms and discriminatory attitudes must be reduced through systematic reforms, transparent evaluation systems, and active efforts to challenge bias in medical education and professional practice. Only by advancing both structural and cultural change can Japan create an environment in which female doctors

are able not only to remain in the workforce but to advance their careers. Achieving this will not only promote gender equity but ultimately raise the overall quality, inclusiveness, and effectiveness of healthcare, strengthening public health for the entire population.

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