

Women in hospital medicine

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The proportion of women in the UK medical workforce is rising steadily. While this is good news for sexual equality, and is welcomed by patients who wish to have the choice of a woman doctor, it has implications for workforce planning. Women are much more likely than men to wish to train and work part-time in order to accommodate the demands of producing and caring for a family. Specialties that attract a preponderance of women need to plan for lower rates of participation by their workforce, both during and after training. Specialties traditionally attracting a preponderance of men need to consider the shrinking size of their recruitment pool as the absolute number of male graduates falls. A working party of the Federation of Royal Colleges of Physicians (Edinburgh, Glasgow and London) has produced a report *Women in Hospital Medicine*¹, which considers the impact of women in the medical specialties and compares their aspirations and achievements with those of men.

The working party reviewed the literature on the role of women in medicine and heard evidence from experts in the field; women doctors currently in training; women who had achieved academic success; and associate postgraduate deans with responsibility for flexible training. While the focus was on hospital medical specialties in the UK, they also considered the experience of women in other specialties and other countries. The resulting report presents evidence that the increasing proportion of women in medicine has profound implications for the future staffing of the NHS, at least equivalent in impact to the changes brought about over the last 10 years by the reduction of junior doctors hours. It found that women tend to shun the acute medical specialties; tend not to apply for senior academic jobs; are not well represented in the senior management and administrative positions; and are under-represented in the top distinction awards. While not advocating positive discrimination, the report offers recommendations to retain and maximise the contribution of women in hospital medicine.

Working conditions

Women doctors, like women in general, tend to spend fewer hours per week at work than men. The difference appears to relate to the sharing of domestic duties between the sexes. Women not only

bear the children, but tend to take more responsibility for their care. The more children a woman has, the fewer hours she will tend to work outside the home, while the reverse is true for men, both in medicine² and in general³. Women are also much more likely to take responsibility for dependent parents. The report recommends adequate child-care places with out-of-hours provision within the NHS, and the availability of part-time and flexible training opportunities and consultant posts.

The future for flexible training

The flexible training scheme, whereby trainees with well-founded reasons for being unable to train full-time can opt to train through an individualised programme that takes into account their need for reduced hours and any geographic constraints, has been generally acknowledged as a success. Such training has traditionally been provided through supernumerary placements. The report explores the rising uptake of flexible training, which doubled in the medical specialties between 1994 and 1999. It draws attention to the difficulty inherent in accommodating increasing numbers of flexible trainees in supernumerary posts and recommends the development of more job-sharing schemes and established part-time posts. What the report does not address is the likely impact of recent pay bands on the future of flexible training⁴. Under the new agreement, trainees working part-time but doing any out of hours work are paid a full basic salary, irrespective of the number of sessions worked. The extent of the on-call commitment determines the intensity supplement they receive in addition, but where this is significant they will be earning as much as their full-time colleagues, while working fewer hours. At one level this may be hailed as a benefit for women who have struggled to make ends meet on part-time salaries. On the other hand it has had a predictably negative effect on potential employers, faced with having to pay the same for a part-timer as for full-time staff. Even if this scheme were to be fully funded centrally, so that the disincentive to employ flexible trainees were removed, there are other unwanted consequences of the pay award. One of the reasons for dissatisfaction with flexible training is the way it is perceived by consultants and peers, who sometimes resent the ability of flexible trainees to dictate their hours and choose

their placements⁵. If they are seen to be paid the same as well, it is likely that resentment will increase. A full basic salary for part-time trainees has also had a negative consequence for the postgraduate deans administering the scheme. Hitherto it has been possible to be generous in the interpretation of eligibility. However, if there is no financial disincentive for the trainee in reducing sessions, then postgraduate deans may feel impelled to be more restrictive, and to worry whether the sessions released are being used for alternative employment. How the scheme will survive this generous and well-intentioned pay award remains to be seen.

Part-time consultant posts

The report presents evidence from a specially commissioned survey of senior house officers who had just passed the MRCP(UK), indicating that 39% of women and 12% of men would definitely plan to work flexibly at some stage in their career. This accords well with the results of a survey of specialist registrars in the medical specialties, in which 34% of women and 6% of men definitely or probably intended to work part-time as a consultant⁶. These intentions are not confined to the medical specialties. A survey of specialist registrars across all specialties in one region, using methodology previously reported⁷, revealed that 34% of women and 5% of men intended to work part-time after their training was completed. 'Domestic commitments' was the reason given by 76% of women and 16% of men. The percentage of women intending to work part time after training varied by specialty: 52% in psychiatry, 36% in paediatrics, 31% in medical and surgical specialties, 28% in anaesthetics and 19% in obstetrics and gynaecology. Meanwhile, very few part-time consultant posts are advertised. Without some central initiative to encourage employers to offer part-time posts it seems likely that some of these expensively trained doctors will drop out or accept a sub-consultant career grade post, if the only other alternative is working full-time.

Academic medicine and positions of seniority

While the paucity of women holding senior clinical and academic posts is largely explained by the fact that it is only ten years since women made up 50% of the medical school entry, the proportion of women reaching senior levels is still less than would be expected, all else being equal⁸. The reasons for this 'glass ceiling' may include an apparently lower level of ambition among women graduates: in a recent study, 25% of British women trainees and 10% of men indicated a preference for a career grade post that did not have the full range of consultant responsibilities⁹. Other countries have a similar experience. In the USA, despite the growing number of female academic physicians over the past 20 years, advancement to full professor or dean is still comparatively rare. Studies have reported lack of advancement among female faculty members in US medical schools¹⁰ and slower academic promotions¹¹. Anxieties about recruitment and retention of clinical academics in the UK has led the newly formed Academy of Medical Sciences to consider

the difficulties facing the successful trainee with domestic commitments. A recent report recommends improved publicity for the availability of flexible and career re-entry research fellowships; facilitation of return after maternity leave, extending grants where necessary; proportionately greater research support costs, for example for extra technical support; and a change in culture and attitudes to flexible training and working patterns¹².

Conclusion

This report from the Federation of Royal Colleges of Physicians is a timely call for action. There needs to be an end to the assumption that a medical career requires total commitment at the expense of family life. The NHS should enable all its staff to achieve a reasonable work/life balance, and should recognize that with over half the medical school intake now female, the pattern of work for doctors must reflect their other commitments. At the same time, the contribution of those who are able and willing to commit more of their time to the NHS should be valued and recognized. A growing excess of women over men in medical school admissions is no healthier than the opposite, and may lead to shortages of applicants for surgery, acute medical specialties and academic or senior management posts. Patients have the right to see a male doctor if they choose. Balance and diversity are the keys to a successful and effective workforce.

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