Women in Medicine:

Opportunity Blocks

Key facts

One
Two-thirds of new medical students are women, yet less than 30% of consultants, 11% of professors and 36% of senior lecturers are female.

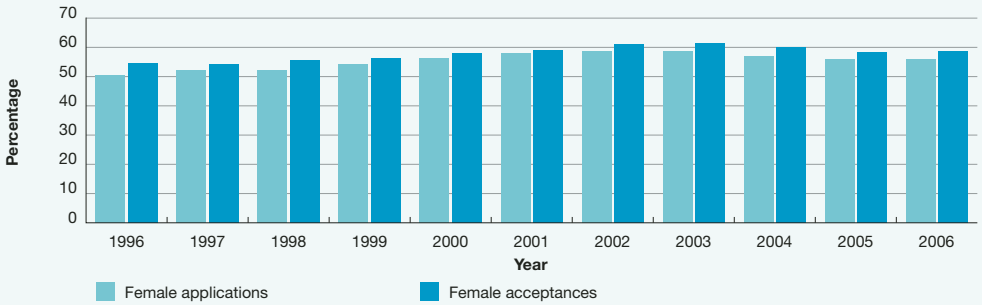
Two
Studies of women doctors' attitudes and experience show that many regret entering the profession because of the barriers to career progression that they encounter.

Three
European Union data identify the main obstacles to maintaining women in the general workforce as inflexible working hours, poor childcare provision and an absence of tax incentives.

Four
Similar obstacles confront women doctors and are exacerbated by the work patterns in modern medicine (particularly the need for 24-hour cover); the hurdles in academic medicine appear particularly unfriendly to women.

Five
Whilst the NHS was an early pioneer in flexible working and provides childcare in the workplace, these measures have not been developed sufficiently to address the fundamental problems that impede women doctors' careers.

Figure 1: Large numbers of women apply and are accepted to medical school



Source: Universities and Colleges Admissions Service

In the latter part of the 19th century, a young woman made medical history. Not through an invention or a medical discovery, but by breaking a gender boundary. Elizabeth Garrett Anderson faced many hurdles, from unsympathetic students, medical schools and authorities. She succeeded against the odds and was the first female doctor trained in the United Kingdom to be entered on the medical register.

Today the problem is not access to medical school but rather how we ensure that the female medical workforce is able to fulfil its potential once in employment. Today, almost 60% of acceptances to medical school are female and yet less than 30% of consultants are female. At 15 years post graduation, 60% of women are working compared with 80% of men.

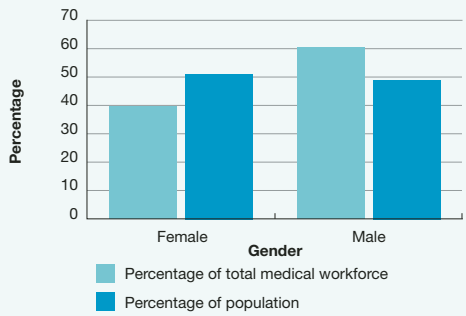
Why are women still not better represented in the medical workforce? Today, 55.8% of applicants to medical school are female and a remarkable 58.7% of all those accepted are women. These high levels have been sustained over the last decade (see **Figure 1**). However, when the position of women is examined in the medical workforce overall, the picture is less encouraging.

The 2001 Census showed that women make up 51% of the country's population. Only 40% of the NHS hospital medical workforce and 45% of the general practice workforce are women (see **Figure 2**). Whilst some people may not find this surprising, it is important to recognise that this is a lower percentage than other equivalent professions such as civil servants (see **Figure 3**).

Across the grades of doctors, the increase in female medical students is starting to make an impact. In 2006, 60% of doctors in the first two postgraduate years were women. However, the percentage of women in each grade drops with increasing seniority so that women make up less than 30% of the total consultant workforce (see **Figure 4**). The representation in academic medicine is much worse: only 11% of professors and only 36% of senior lecturers are women.

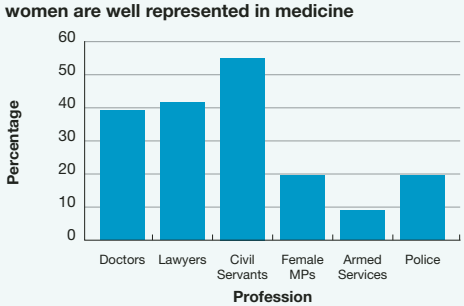
While superficially it may seem that women receive less financial reward and recognition for their service, as demonstrated through clinical excellence awards, analyses that control fully for other factors, such as length of service, disprove this. The clinical excellence award scheme is a supplement to the consultants' salary scale awarded after peer review and managerial assessment of the doctor's achievements. It replaces the former distinction awards system. It is strongly linked to length of service. Those who became consultants between 1962 and 1976 are over 500 times more likely to be recipients of awards than those who gained consultant posts between 1997 and 2001. Since women make up less than 10% of the workforce in the oldest consultant cohort, mainly due to previous restrictions on medical school acceptances, they tend to receive fewer awards. If year of appointment to consultant grade is controlled for, then they do not fare worse than their male counterparts. As women begin to make up more of the consultant pool, they should receive the equivalent proportion of awards.

Figure 2: Percentage of women in the total medical workforce is low compared with the general population



Sources: The Information Centre and 2001 Census of Population

Figure 3: Compared with some other professions women are well represented in medicine



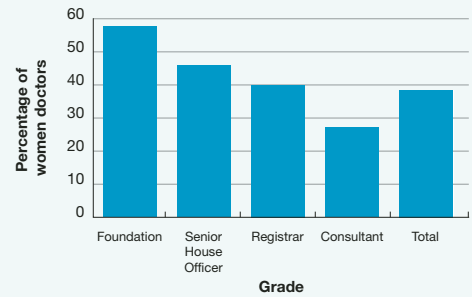
Sources: The Information Centre, Civil Service, Ministry of Defence, House of Commons Information Office, The Law Society, Office for National Statistics

At both individual and group level, women have demonstrated that they are vital to the medical profession. Medical school and workforce data show a greater feminisation of medicine, but will the ratio of female to male doctors improve further and reach parity? If not, will it be because of choice or because the later stages of a career in medicine are more difficult for women than for men?

The whole story?

Studies that have examined the experiences of women doctors give a consistent message: despite more women entering the profession, many experience difficulties directly attributable to gender. The Women Physicians' Health Study in the United States found that a third of female doctors would not choose to do medicine if they had their time again, and this view was highest amongst younger women. Another study by the American College of Surgeons showed that nearly half of all surgical residents agreed with a statement that female doctors suffered discrimination. In a study of female paediatric surgical consultants in the United Kingdom, 70% felt that their development had been hindered by their gender.

Figure 4: Percentage of women doctors is highest in the more junior grades



Source: The Information Centre

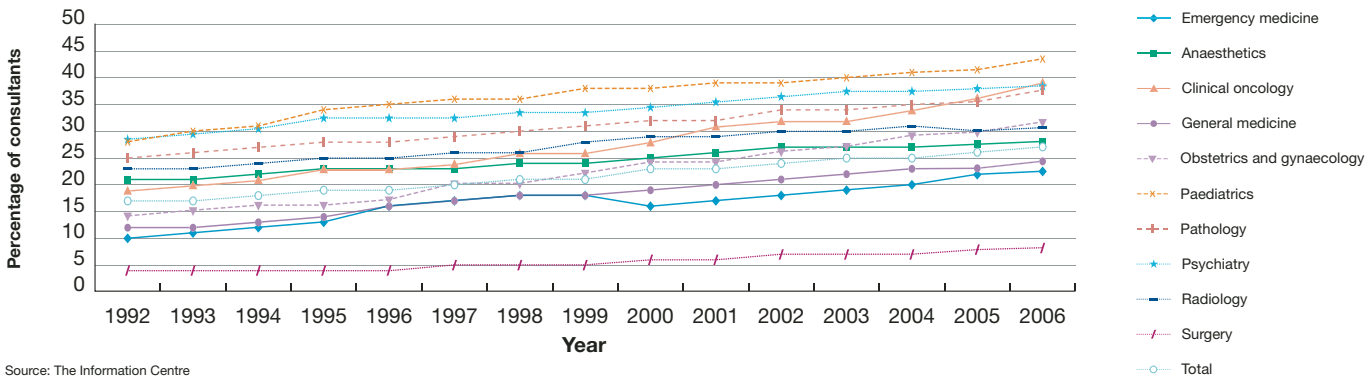
"Even today, women are substantially under-represented in the medical workforce."

Women doctors manage the system as best they can and cope with many hurdles. Thus, a purely quantitative assessment does not shed light on the reality. Women may well remain in the workforce and even reach consultant level, but have they had to change specialty to succeed, or have they had to put other important aspects of their lives on the line to do so? For example, women may not make the level of professor or senior lecturer because of the complex interaction between lifestyle and career. Women in academia generally have fewer publications than men, often because of a gap in production of papers during child-bearing and rearing years. Producing fewer papers, even for a short while, can affect promotion prospects and therefore career progression.

Studies have repeatedly shown that women are more likely to make career choices based on family decisions than men (although many of today's male doctors also want increased flexibility to decide their own work-life balance). There is little doubt that the choices of a career in medicine do show gender specificity and not all of this is attributable to external factors. Women do want different things out of their jobs and this leads, for example, to more women in paediatrics, despite the high work intensity and time commitment. Although overall percentages of women doctors are increasing, the proportion entering many specialties has remained fairly static, in particular surgery (see **Figure 5**).

These issues are fundamental because, as the young female students and trainees of today progress to be the consultants of tomorrow, adequate planning is necessary to ensure that NHS workforce needs are met. Data from 2002 medical school graduates show that only 10% of women are considering a career in surgery compared with a third of men. These issues are even more pressing with the demands of meeting the European Working Time Directive and the desire expressed by many women (and men) to work part time. A recent survey by the British Medical Association identified that 70% of women questioned are either already working part-time or would like to.

Figure 5: Proportion of women consultants in most specialties has increased but remains low in surgery



Source: The Information Centre



The need for action

Data from the European Union show that the obstacles to maintaining women in the workforce in general are inflexible work hours, poor childcare provision and an absence of tax incentives to encourage them to return to work post childbirth.

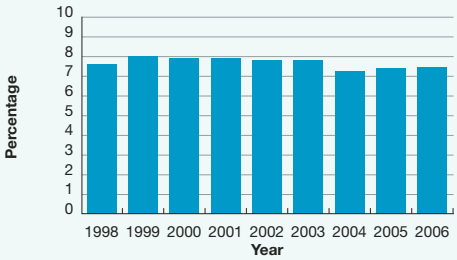
As part of the NHS Plan, the NHS childcare strategy committed to providing 150 more on-site nurseries, 7,500 extra subsidised places and for all providers to have access to a childcare coordinator, to help them maximise benefit from the current system. Whilst this target appears to be on track for achievement, it is clear that the nature of the provision required is changing. Many women doctors have jobs beyond a conventional nine-to-five pattern, and childcare provision outside these hours is much less available. Doctors in training often change jobs frequently. Waiting lists for childcare are often long and by the time a vacancy for childcare arises, the doctor may be moving to another post.

Increasing numbers of clinicians at both junior and senior level are working shifts. Over one-third of the doctors surveyed in the NHS National Staff Survey reported working at night. However, a recent study of NHS childcare provision showed that only 5% of facilities opened during the weekend.

There is a further need for childcare that provides relief for emergency situations, such as failure of normal childcare. Equally, whilst school-age children are provided for in school time, holiday time can be problematic. Although it is understandable that childcare providers have not been willing to meet these needs to date, a Joseph Rowntree Foundation study identified that a third of childminders would consider atypical hours if they could charge higher fees.

A Healthcare Commission report identified that childcare costs are squarely placed on the individual with limited help from employers at present. In the last few years, the ring-fenced monies that were provided centrally for expansion of childcare have become part of general NHS budgets. There is a risk that these budgets could be soft targets. Yet, the benefit for NHS employees can be significant. King's College Hospital NHS Trust reviewed its provision and found that creating 60 new childcare places in 2003 correlated with a reduction in the overall staff vacancy rate (13% to 7%) and a reduction in the use of bank and agency staff (60,000 hours to 50,000 hours).

Figure 6: Percentage of medical staff who work part time and are female has remained constant since 1998



Source: The Information Centre

The United Kingdom was an early pioneer in flexible careers and returner schemes for doctors, but this commitment has not been maintained. All the existing schemes have seen recent cutbacks in funding and rule changes. In the last eight years, the percentage of the medical workforce that is female and works part time has remained static at around 8% (see **Figure 6**). Data from the Conference of Postgraduate Medical Deans suggest that there was a decrease of 15% in the flexible training posts available last year. This is despite the rising percentage of women in the workforce. The wait for such posts can be significant. In some cases, women are now waiting for vacancies in part-time slots before they can return to work after childbirth. In addition, it is often up to individual women to facilitate job shares. These impediments will obstruct the progression of talented women in whom much has been invested, and jeopardise the success story of increased numbers of women entering the workplace. This also represents a potential break in the continuity of experience that female doctors are able to offer the service.

In business, there has long been a concern that there are insufficient women in key positions in the top FTSE 100 companies. To address this, the business community has set up schemes to help women who are nudging the glass ceiling to make it through. Pairing these talented individuals with mentors, who have contacts and understand the system, enables these women to make the right career choices. Study after study has identified that finding a good mentor is critical to career advancement.

There are some similar initiatives in medicine. For example, Women in Surgical Training has 2,000 members and specifically addresses some of the needs of female surgical trainees. Networks like the Medical Women's Federation also offer further opportunities.

Ensuring that there is a medical workforce fit for purpose in the 21st century means addressing more forcefully some key areas where change will make a big difference: greatly expanding flexible working opportunities; protecting local budgets for childcare; ensuring that nursery premises operate much more flexibly; and continuing and strengthening mentorship schemes for women doctors.

Elizabeth Garrett Anderson would have been justly proud that 150 years after her inaugural steps the world of medicine is so different. Today, the number of women entering medicine must mean that a new era is upon us. Creating an environment in which obstacles are reduced and excellence is encouraged and rewarded justly would be a fitting tribute to a remarkable woman and the many that have followed her.

Women in Medicine: Action Recommended

"Today the problem is not access to medical school but rather how we ensure the female medical workforce is able to fulfil its potential once in employment."

- The number of flexible training places for doctors should be expanded.
- A national working group should be established to recommend changes to workplace childcare provision which are matched to the needs of women doctors.
- In surgery and other specialties where the proportion of women is low, mentorship schemes should be reinforced.