

Women Doctors

Isobel Allen

I would like to start by looking at some of the background to the PSI study. Some of you may know that Pat Walters and I have been in the field for twenty years. In 1968, in our first Women in Top Jobs study, we looked at women's careers and their prospects in industry (Fogarty et al, 1971). We went back again in 1979 (Fogarty et al, 1981) to see what had been happening in the eleven years since our research. Since then Pat has been doing other things, I've been doing other things, but I returned to look at the careers of women doctors related to the careers of men doctors.

This paper is about the research I carried out for the Department of Health on doctors' careers (Allen 1988a; 1988b). I would like to look at four main areas: first, careers advice and counselling at school and at medical school during post-graduate training and beyond; secondly, medical career structures and the constraints and difficulties which doctors experience in pursuing a career in medicine; thirdly issues surrounding appointments, promotion, patronage and equal opportunities; and fourthly, the question of part-time training, part-time career posts and job-sharing. The full report covers many more aspects of doctors' careers but these are the four areas that I will concentrate on in this paper.

The point of departure for the study was the fact that women will soon, very soon, account for 50 per cent of those entering medical school. The proportion has been rising steadily from around 25 per cent through the 1960s, to 35 per cent in 1975, 46 per cent in 1985 and it really looks as though that 50 per cent figure is about to be cracked,

and indeed it is more than that in certain medical schools. The DHSS, as it then was, initiated and funded this research because it recognised that the contribution of these women doctors is a key factor in future medical manpower planning. There were four main aims of this research. First of all, to collect more information on changes or trends in the activity or participation rates of women doctors; secondly, to identify the main obstacles which prevent women from participating as fully as they would like in medicine; thirdly, to examine the usefulness and relevance of careers advice in medicine at all stages from school to post-graduate training and beyond; and fourthly, to assess the extent to which women doctors have found their aspirations limited more by the actual medical career structure than by their own ambitions.

Around 13 per cent of hospital consultants and nearly 20 per cent of GP principals are women. Now these are the career grades. These are the top jobs in medicine. But these figures include doctors of all ages. The proportion of women among new recruits to these grades has been creeping up gradually, as one might expect, but nevertheless, women doctors still have a long way to go before they can claim anything like parity with men. And in some specialties such as surgery, where 2 per cent of hospital consultants are women, they have a very long way to go indeed. Although the main aim of the research was to look at the factors affecting the careers of women doctors, we decided at a very early stage to place the research very firmly within the context of the careers of doctors in general. There have been signs of discontent with the medical careers structure for some time now and we thought it important to examine the factors affecting career or specialty choices of women doctors against the background of how such factors might affect the careers of all doctors. We also decided to base the study on the experience of relatively recent qualifiers since we were interested in looking at the future. We also confined the study to qualifiers from British medical schools, again because we were looking at the future when there will be decreasing numbers of overseas qualified doctors around. My colleague, David Smith, had already looked at the careers of overseas doctors some years ago.

So what did we do? We looked at three years of medical qualifiers, from 1966, 1976 and 1981. They were around 43, 33 and 28 at the time that we interviewed them in 1986. We aimed at achieving personal interviews with random samples of 100 men and 100 women

from each of these years of qualifiers and, in the event, we interviewed 640 doctors: 314 men and 326 women almost literally from Land's End to John O'Groats. We followed them round the country from their last known address and we developed considerable sympathy with those who complain about the constant moves that young doctors are expected to make. That was a real piece of detective work. Both the men and the women had a great deal to say in the interviews, and it is one of the few studies I've ever been engaged in where so many doctors were so happy to be interviewed.

I would like to set the scene by looking at the careers of the doctors we actually did interview. It was no surprise to find that the vast majority of the men qualifiers from 1966 had reached career grade, as consultants or as principals in general practice, while the proportion of women who were working in career grades was considerably lower. They were much more likely than men to be found in community health or working as clinical assistants. These are not training posts and they are not career posts. They do not lead anywhere and they are not the top jobs. A similar pattern was emerging among the 1976 women qualifiers, while among the 1981 qualifiers, women appeared to be level-pegging much more than men. The big difference between the men and the women was the proportion who were working part-time, or rather less than full-time. And I should stress that part-time work in medicine is really like full-time work in any other area of work. Full-time work in medicine, particularly among hospital junior doctors, is around eighty hours a week. Part-time work in medicine is certainly usually more than forty hours a week. This is something I think one should get very firmly in one's mind when one is talking about this.

Now virtually all the men we interviewed were working full-time in clinical medicine, compared with just over half of the 1966 women and just over 40 per cent of the 1976 women. Nearly three-quarters of the 1981 women were working full-time. I think I should stress, and I was very interested to hear what was happening in the other professions, that the vast majority of these women doctors had really kept working throughout their careers. There was very little evidence that they had stopped work at any time, for any length of time, to have children or to bring up families. It was much more common for them to have continued in part-time work than to have a break. This report gave plenty of evidence that women doctors are very highly motivated

and dedicated to their profession and again one might argue that they have the opportunities to work part-time which perhaps women in other professions and in management do not have. They had certainly not dropped out. Only 5 per cent of the women in each of these years of qualifiers were not working at all at the time that we interviewed them, and most of these regarded that as a temporary situation.

Now this pattern has been found in other studies of women doctors and really should not be surprising. There is a popular view around that there is a great pool of women doctors that you would only have to tap into and they would all come flooding back in if they knew how to. Our research suggested actually that this pool was small, that it is by no means homogeneous and that these women are not lost to medicine. Most of them intended to return as soon as possible and employers seeking to make the best use of the skills of women doctors should really look elsewhere.

Careers advice

I want to talk about career advice because this was a very important factor that went right through the study. One of our most important findings was the extent to which the career advice and information given to doctors at all stages of their career was thought to be haphazard and of poor quality. It was said to be particularly true of careers advice at school and, perhaps more importantly, it was also said about careers advice at medical school. It was also stressed that careers advice in the post-graduate years was also very poor. I think the lack of advice about a medical career at school has very important implications. There is little indication that the doctors had been given any idea by their schools of what they were embarking on by entering medical school, which was too often seen as an accolade for the school, and as a desirable aim for a student who was good at science; or, on the other hand, as something that was very competitive and not to be attempted by students who were not brilliant at science, particularly if they were girls. The main reason given by both the men and the women qualifiers from 1981 for wanting to study medicine was because they were good at science subjects at school – and they were very good at science subjects at school. It was particularly striking among the men, and I actually wondered whether it was the best reason for becoming a doctor.

The majority of the doctors we interviewed said they had little idea when they went to medical school of what they were letting themselves in for, either in terms of life as a medical student or in terms of the training needed after qualification; in terms of the career options open to them, or in terms of the reality of life as a doctor. They certainly had little idea, if any, of the length of higher professional training in medicine or of the difficulty of combining a satisfactory home life with the demands of such training. It was true of men and women, whatever their background.

This 1976 qualifier, a man, might have been in a better position to judge this than most, since his father had been a GP, but nevertheless he reflected the views of a lot of his contemporaries when he said:

When you go into medicine as a kid, you go into it as a dream rather than a reality. One of those realities is that the road is a lot longer and a lot harder than you imagined.

So many doctors like him describe their initial decision to apply for medical school as naive and based on an unrealistic assessment of medicine as a career, fostered by home, school and the popular image of doctors. One of the women in our study summed it all up when she said, 'Dr Kildare let me down'. Perhaps it was not surprising that a substantial minority of the doctors we interviewed, men and women, said they regretted their decision to become doctors and many of them echoed the views of this 1981 woman qualifier who said:

Much as I enjoy medicine, I feel trapped by it. If I'd known what I know now, I wouldn't have done medicine at all.

Career advice at medical school was thought to be almost as bad, and indeed 99 per cent of the 1966 qualifiers said they had received no formal careers advice at medical school at all. I think this seems astonishing when you consider what a vocational career medicine is. It was a bit better for the 1981 qualifiers, but the advice given was rarely thought to be good. Doctors from all years thought there was a great need for improved advice at medical school, about potential careers in medicine and certainly for more guidance and support.

Medical students often appeared to be taught in ways which other students would find quite unacceptable, and there was a lot of evidence in the study that there was a need for a more humane approach to the treatment of medical students, who often seem to find themselves in very stressful situations with what appears to be little support from staff. There was agreement that women medical students needed some

kind of special advice particularly on specialties and careers which they can fit in with family and most especially with part-time training. We concluded, however, that there was an urgent need for medical students of both sexes to receive much more realistic advice on career opportunities and specialties, including the most fashionable or less well-known specialties, and on the lifestyle and demands of different specialties.

Medical career structures

I have assumed rather a lot of knowledge about the medical career structure. I don't want to go into a lot of detail, but I will talk a bit about it because it affected the careers of the doctors to such a large extent and I want to talk a bit about the constraints and difficulties which they encountered. There was no doubt in the minds of men and women from all years of qualifiers that competition for jobs is increasing and many of the problems which doctors mentioned flow from that. There were complaints about what was perceived to be the inflexibility and rigidity of the career structure, about the constant need to scramble for jobs, always looking for the next job as soon as they had started one, about the need to move around all the time, often round the country, about the difficulties of combining family and career, particularly if they are married to other doctors which many of them were, about the long hours and the intensity of on-call responsibilities and about the lack of time available to study for higher professional qualifications which were increasingly seen as the only passport to success. There were also many criticisms of the conditions of service particularly in hospital medicine. At the same time it was thought that the hospital career structure increasingly demanded a straight career path with no deviation into interesting or stimulating sidelines. It was thought dangerous to go abroad for experience unless you were a real high-flyer, and the system was certainly thought to militate severely against careers which could in any way be called different. Now that course included careers in which people took longer to get anywhere than others did. So if certain career patterns presume certain lengths of time in certain grades or in good jobs within those grades, women who worked part-time or had a break for any length of time or were not geographically mobile were at a distinct disadvantage. Such careers, or doctors pursuing them, were considered 'unsound' according to our respondents.

There was a general perception that employers in the medical profession assumed that 'sound' doctors would reach certain grades by a certain age. Now this linking of age to grade, which Pat Walters and I saw becoming more rigid in our study in 1979 (Fogarty et al, 1981), was undoubtedly something which was thought to work to the disadvantage of women, who might reasonably take longer to complete their training – this is their higher professional training, their post-graduate training – because of their domestic commitments. Doctors qualify at the age of 23 or 24 and then have to do a pre-registration year which takes them to 24 or 25. That is only the start. If you are going to be a GP, you have to do three years of vocational training – two years in a hospital, one year in general practice. If you are going to be a consultant, it takes usually at least ten years before you become a consultant and in the case of surgeons and general medicine, you are quite likely to be 38, 39, or up to 40, before you are actually a consultant. That is a very long time to be in a training post or to be a 'junior doctor' as they are called while they are in the training grades.

I think that the problems seem to be getting worse rather than better. Some of the 1966 women consultants and GP principals had had very chequered careers in which they had changed specialty more than once and moved around the country to follow their husbands' careers. They had had babies more or less on the job, or so it seemed, and yet they had still managed to reach career grade. They had often shown enormous resourcefulness, and some of them were less than sympathetic towards the younger doctors who 'wanted their cake and eat it'.

There is certainly a widespread fear that the present medical career structure combined with what many saw as the increasing importance of personal patronage in careers advancement would tend to work to the advantage of 'conventional people with conventional careers', which many thought counted out most women who might be conventional enough as people but were not able to follow conventional careers.

It is normally assumed that the main constraints on women's careers are caused by marriage and children and that there is little that can be done about it within a profession. Of course we found that marriage and particularly children were thought to be major constraints on the careers of those who were married or who had

children, but this was true of men as well as of women. But there was absolutely no doubt in the minds of those who were interviewed that it was the way in which medical careers were organised which caused the greatest problems in this respect. The frequent moves and the long hours were thought to be potentially disastrous to relationships and marriages. The question of career constraints caused by children was thought to be somewhat academic by some of our respondents as this young woman doing one of her Senior House Officer jobs explained:

It's not really applicable. I see my husband so seldom, it makes the logistics of having them impossible.

We heard a great deal in our interviews about the difficulties faced by young doctors in trying to lead a normal life. The problems faced by the young women in attempting to combine a satisfactory home-life with a satisfactory career were shared by the men. One of my strongest impressions of this research was the similarity between men and women doctors, rather than the differences. Indeed there were many indications that there were greater differences between the three years of qualifiers than between the sexes, and I think that the way forward in research of this kind is always to compare, if possible, men's and women's careers.

I think the 1981 qualifiers were rather different from their predecessors in certain ways and I think that these differences have important implications. Both the men and the women who qualified in 1981 were much more critical of the system than the earlier qualifiers. I do not think this was just a reflection of their age or the stage they were at in their careers. I think actually the differences were more fundamental than those. They pointed out that life might have been tough for older doctors, who never ceased to tell them how tough it was, but at least they had the guarantee of a reasonable job and a good salary at the end of it. These young doctors, looking around them, saw no such guarantee in front of them and many of them looked forward with pessimism. There was a very high level of regret about the decision to become doctors among these young qualifiers, even among those who on the face of it had had very successful careers with the right jobs in the right place at the right time. Nearly half of the 1981 women qualifiers, and over 40 per cent of the 1981 men qualifiers said that they had regretted their decision to become doctors.

Appointments, promotions and equal opportunities

I would like to turn to the third of my main themes and that is appointments, promotion, patronage and equal opportunities. We had thought that personal patronage in medicine would be a thing of the past, but in fact it seemed to be getting more rather than less important. Nearly three-quarters of the 1981 qualifiers thought that it was important or very important. And these younger doctors disapproved of it much more than the older doctors. There was evidence of a great deal of bitterness among younger doctors about a system of careers advancement which they deplored. There were criticisms that promotion and good jobs depended too much on word-of-mouth recommendation. Behind the scenes, there were reservations about a system that was said to be resistant to change and encouraged sycophantic behaviour among young doctors and could lead to the perpetuation of an old-boy network which excluded women. I should point out that the system was criticised mainly for its secrecy and lack of openness, and it was thought to discourage change in the medical profession which was described as being 'extremely conservative'. There was considerable unease about a system of promotion which was thought to depend so much on luck, good fortune, personal recommendation and stumbling across 'Mr Right' at the right time. There was evidence that women found it more difficult than men to cultivate friends in high places.

As far as appointments and interviews were concerned, there was no doubt that women doctors were seen as a risk by those making appointments. This was made fairly plain in the types of questions about personal circumstances which were put to women and not to men. Women were much more likely than men to be asked whether they intended to have children and much more likely to be asked what arrangements they would make for the care of their children, even if they didn't have any. I must point out again that questions about intentions to have children appeared to be increasing rather than decreasing. Other questions about private lives were quite extraordinary. They were seen to be intrusive and insulting and they were sometimes thought to be way beyond the acceptable. It was quite clear that many of them could be interpreted as indirectly, if not directly, discriminatory and it does appear that the medical profession needs to look very closely at the extent to which the present system of

careers advancement in medicine allows for real equality of opportunity.

Part-time training and careers

The fourth theme that I am going to look at hinges around what can be done in structural terms to improve opportunities for women doctors by the provision of more part-time training and part-time career posts. The hospital training posts are the grades of senior house officer, registrar and senior registrar. GP trainees in general practice are in training grades and there are training grades in community medicine. Career posts are principals in general practice, hospital consultants, specialists in community medicine or regional or district medical officers.

The main difference we discovered between men and women doctors was the extent to which the women worked part-time. But most part-time jobs in medicine are neither training jobs nor are they in mainstream hospital medicine. We looked in detail at part-time training because it is so crucial to the future progress of women in the medical profession. Everyone, or almost everyone, thought it was a good idea, but then the problems arose. It was thought to be difficult in the acute specialties, surgery, general medicine and obstetrics and gynaecology. It was feared that part-time training was thought to be of lower status than full-time training and that supernumery jobs, which is what the main part-time training jobs are, were not regarded as being proper jobs. It was thought that part-time necessarily meant daytime and weekdays, and there was a general ill-defined feeling that certain specialties needed continuity of care which could only be provided on a full-time basis. It was of course queried whether the length of time spent in training posts in this country was really necessary. Very little was known about the main scheme which facilitates part-time training which is the PM(79)3 scheme which few people understood. It might not matter that over 80 per cent of the men had never heard of it, but it must surely be a cause for concern that over 60 per cent of the 1966 and 1976 women qualifiers and 80 per cent of the 1981 women qualifiers had also never heard of it. Even among those who knew something about it and even among those who had some experience of it, there was considerable misunderstanding of how it works. It certainly helped women to train part-time, but it did appear to have been very complicated and what many described

as an uphill struggle. It is very interesting that the few women who had done it often mentioned a couple of very eminent women doctors who have made it their business to ensure that women train part-time in this country. It did appear that there was a need for a much more improved publicity and information about this scheme.

The advice given to women who were considering part-time training was yet again considered to be patchy, often misleading and sometimes downright discouraging, even from people who were allegedly there to encourage women to continue with medicine. Some of them had struggled on with full-time training when they would have preferred to train part-time, at least for some of the time, whilst others of them were in non-training, non-career posts when they wanted to be in training or career posts and they felt their skills and talents to be grossly underused. Others had left medicine or were not working.

I would like to talk briefly about job-sharing. It was one of the most frequent recommendations which was put forward by both men and women when they were asked how a greater availability of part-time training might be achieved. But most people seemed to be very unaware of the very real practical problems which arise because of the small numbers of people involved. Job-sharing must assume two people in the same specialty, at the same stage, in the same place, at the same time who both want to job-share. Now this may not actually occur very often outside the main centres and the main specialties in the main cities. However, one of my main recommendations was that job-sharing required a very close examination, not only in training posts.

There was also considerable support for part-time or less than full-time career posts, again not only among women, and, again, job-sharing or split jobs were advocated. Certainly there was evidence that general practice offered much more in the way of part-time career posts to women than hospital medicine did.

I'd like to talk briefly about general practice. There was no doubt at all that the younger women wanted 'proper' jobs in medicine and that did not mean for them jobs in the family planning clinic or being a school doctor. They expressed a real reluctance to go into community health. We asked people what their career intention had been when they first went to medical school, at the end of medical school and at the end of their pre-registration year and we compared these intentions with what had happened to them. Nobody had

actually ever wanted to go into community health but a lot of the 1966 women ended up in it. The younger women said they were not like that. These younger women saw their future in general practice, and they were opting for it at a very early stage, but, unfortunately, so were the men and they were all flocking into general practice. Many of the more severe criticisms about the career structure were levelled by doctors in hospital medicine and there was no doubt that general practice was seen to be a much happier hunting ground for both men and women than hospital medicine. Patronage was also thought to be less important. There was evidence of much better teaching about general practice among the 1981 qualifiers at medical school than the older qualifiers. But general practice is therefore becoming much more competitive for both men and women, and there were fears that opportunities for women doctors in general practice could be getting much tighter.

So we concluded that there were definite constraints on the careers of women doctors. I think it has to be recognised that at a time when young women are ready and able to break into the higher echelons of the medical career structure, many factors are stacked very much against them. If women are to be better represented in medicine, particularly in hospital medicine, I made a very strong recommendation that there will have to be changes in the medical career system, which is geared essentially to a totally full-time commitment among doctors in their late twenties and early thirties. Full-time working in medicine training posts make demands which effectively rule out much family or social life. It was increasingly unacceptable to men and it was found to be virtually impossible for women, however ambitious and however resourceful they were. And we found plenty of evidence of women doctors being very resourceful and very committed and very ambitious.

We concluded that the medical profession must face the fact that very soon half of its qualifiers will be women and if they are to fulfil their full potential and the community is to benefit from their contribution, then change has to come. I think that the evidence presented in my report suggested that an openness to change might well benefit the medical profession as a whole and I think it has been very interesting how the government and others have responded to the research. Government ministers made policy statements welcoming the research on the day of publication. The BMA has set up a working

party, the government has set up a working party with membership from the NHS and the Joint Consultants Committee, and a great deal of interest was expressed at two seminars which were held by the Policy Studies Institute and the Department of Health after this study to look at this problem. It is actually an economic problem. It is a waste of manpower problem and I think it needs to be taken very seriously.

Discussion

Susan Gompels

Your paper initially was talking about the quality of life content in medicine, and in fact the same thing applies in terms of work content and lifestyle to many of the other professions. I think a lot of what you were saying may be echoed in very different professions.

Isobel Allen

I think one of the points I didn't make here but I do make it quite strongly in the book is that the 1981 qualifiers were very different not only in who they were, but because they looked at the quality of life of their contemporaries and they said 'What the hell are we doing?' They saw that their contemporaries had much more money than they had, had arrived at this lifestyle and more money at a much earlier stage than they had, and they actually weren't prepared to put up with it. I think also that they were slightly different in the reasons why they had gone into medicine. Many of them could have become accountants or gone into the city and they just were not actually prepared to put up with the poor quality of life.

Susan McRae

Something that struck me in your talk was when you said everyone believed part-time was a good idea, and then all the problems were listed as to why it causes trouble. It seems to me you can substitute almost anything for part-time. It is a good idea, but of course, it's not a good idea in this area, that area or whatever. Aren't we perhaps

partly on the wrong foot by looking at things to help women be more flexible and don't we actually have to get men wanting a better quality of work life which would include flexibility, part-time training and so on?

Isobel Allen

I think that's an essential part of my work – including men doctors as well as women – and that's one reason why it's had a lot of impact. They couldn't say, 'Oh it's just the women bleating on'.

Richard Scase

I want to take up your point about alcoholism and marital breakdown, and the lack of training, and financial cuts that are going on in medical schools and universities and so forth. Is it perhaps the case with most occupations and professions that training and advice is about the technicalities of the actual job tasks, but the sources of considerable frustration and discontent and disillusionment are associated with the context in which the job is performed? There are all sorts of organisational constraints where, in the context of particular career structures, in the context of particular organisational cultures, such as patronage for example, or ways at which women are at a disadvantage within the context of male networks. Isn't it these sorts of areas where policy could be directed? Not the actual medical side as such and the exercise of particular skills, but the contextual factors. It's there where training and counselling are so inadequate for your intending doctor.

Isobel Allen

Part of our research focuses on careers advice and counselling throughout medics' careers. We give examples in the book of how people were treated at medical school. There is no doubt that they are treated in a different way from other students. A word that was used very frequently was 'humiliating' and particularly during the clinical years, they were put into 'humiliating' situations. They were taught in a 'humiliating' way. This was accepted as being part of the culture, this is how they're taught. The whole idea that anyone might have been assessing how they were going to get on as a whole was totally alien to the medical school structure. You picked it up as you went along, you learned on the job, you met 'Mr Right'. And if that person thought you were jolly good then right, you might do surgery this

week. This very personal ‘learning from Nelly’, this sort of apprenticeship thing, is something that goes right through the medical structure. And it was something that was accepted by so many of the doctors and yet it seemed to me that there were many more 1981 qualifiers who were saying, ‘It is all a load of rubbish. Why are we accepting this?’

Rosemary Crompton

One of the things I don’t think we have an answer for is, why do organisations need people to have these very punishing careers? Why is it necessary to have a group of people who have, when necessary, sacrificed their personal and private lives? What I think we should be doing is perhaps shifting the discussion from the individual to the organisations’ need for these particular kinds of individuals, and to the question of whether the sacrifice of one’s personal life is almost *droit de passage*, to demonstrate that you are worthy of the position in question. Rather than say that’s an interesting analogy etc. etc., say, well, why do organisations need this? I’m suggesting that perhaps it’s the organisations that have to change.

Liz Bargh

I think we must stress Rosemary’s point and Susan’s point earlier about perhaps not focusing exclusively on women, but focusing on people in organisations. I increasingly see reflected what you have seen in the medical profession in industry as a whole that people are not prepared to sacrifice their lives and their families in the way that perhaps they were ten years ago, and that this applies to men as much as to women. Perhaps this should be our focus: ways of keeping people in organisations, not just women.

Andrea Spurling

I recognise a lot of what you’re saying about the medical profession in terms of the structures I’m looking at at the moment – essentially universities but especially Cambridge University. Many of the things that you are talking about – informality, the role of the mentor, the idea of training, hierarchies. So many of the problems that you were talking about seem to apply to other areas. The general point is that it is actually the structure that needs to be changed, and the fact that the problems we’re seeing that have been identified as women’s

problems, but really they are problems for society generally. I think that certainly if there's a way of changing the structure, the whole structure of the organisation, it should be found, because what I'm finding now is that there is also a generational difference. People in the 1980s want to do both things – career and family – at the same time. I'm hearing more and more who are saying 'We want more time, so can we please talk about job-sharing and part-time work'. That's coming from both men and women.

Barbara Ballard

To look at this suggestion about organisations versus individuals it is perhaps a good idea to look at other organisations or other occupations. If you are a Member of Parliament, for example, you are expected to do a very responsible job which doesn't seem to have any links with the number of hours you do. We've seen the same kinds of analyses of women in politics. Women in the House of Commons have actually tried to say that when you look at why we don't have more women in politics, it comes up that there isn't enough time to manage the dual role. In fact it's a similar kind of problem, that it's the nature of the organisation that is giving this picture. I think it would be worthwhile if it was possible to draw together all the professions and the organisations that give the professions their characteristics.

Susan Gompels

That does seem to me to parallel Isobel's case. You can also pick out accountancy as a profession. In almost any large organisation the main career structure, the high status, the high pay, demand that same dedication and long hours and preparedness to move. Even in organisations where they have flexibility, part-time availability, when you actually look at the distribution of people within those organisations you still see the men, who are able to follow the traditional path more easily than women, or the women who are single and choose to go that way, are the ones taking the high-paid jobs. So it does seem to be something within an organisation which requires this dedication in order to demonstrate commitment in some way which seems to be fundamental.

Richard Scase

I think we should also remember that in many management schools and in management textbooks this kind of super-commitment is actually advocated. I have been teaching a course on the theory of management in organisations which has involved reading some of the fashionable tomes like *In Search of Excellence* and so on. The Japanese system, which is a sort of implicit model for what British management should be, is just that. It is a lifetime commitment, it is putting the organisation before your family, it being totally imbued with the culture of the organisation and this is being offered as a way out of our economic difficulties.

Sue Dirmikis

In my work as a careers advisor at university, we have no authority to advise medical students about their career progress in medicine, but we see a great deal many qualified medical graduates who wish to leave medicine. It is my impression that wastage rates are going to increase if they are not already increasing. For example, this year just in my own college alone I must have seen almost a dozen people seriously thinking of leaving.

Isobel Allen

I think this is absolutely fascinating because it is very difficult to be a failed medic. It's very difficult because there's such high expectations of you from your family, from your friends, from everyone. If you've done accountancy, if you have done law, if you have done virtually anything else at university, it doesn't matter what you become and nobody is expecting you necessarily to continue with it. But if you do medicine, first there is an expectation that you'll continue with medicine, and secondly, medics find it very difficult to know what else to do. Once you are in medicine, you are stuck there and it is very difficult to get out. We are back to the counselling again so that people should be able to be counselled to give up before getting their degrees. So many of them go on, they qualify, and they then say, 'God Almighty, is that what lies ahead of me? I don't want to do it'. We did not start this study asking this question when we piloted 'Have you ever regretted your decision to become a doctor?' but everybody in the piloting and the pre-piloting said it. And so we put it into the study and we were astonished actually at the high level of regret.

Sue Dirmikis

But the reason is not that they have failed – it is normally that they look at the lifestyle and they say, ‘there are easier ways’.

Richard Scase

We have just finished a study on men and women managers which confirms your point. We found in our study that managers are becoming increasingly disenchanted with, and disengaged from, the traditional rewards offered by managerial careers. The costs are seen to be far too great for the rewards, and instead they are turning their attention to the family, personal relationships and things of this sort.

Isobel Allen

I also think that the demands of the job are greater than in the past. You can certainly see this in medicine. There was no doubt about the demands on these juniors, with 80 hours a week and the older doctors saying, ‘Oh God, we were working 100’. People are much more ill when they are in hospital. They’re tipped out much earlier so they’re much more ill. There’s an enormous amount of technology. The sheer working conditions are much more difficult for junior doctors than it used to be.

Anne Gibson

I was sitting here thinking what’s the difference between a doctor and a trade union official! One thing that hasn’t been raised yet are the expectations of the consumer. Certainly from the doctor’s point of view and from the trade union official’s point of view, the consumer of our products expects us to work in the evening and to work week-ends and to work what would be regarded as very anti-social hours. I don’t know how one can ever get over that particular demand on doctors, because while I would not expect my accountant to be on hand at half past eleven in the evening, even if I was worried about my finances, if I’m feeling desperately ill, I think I would expect my doctor to come on demand.

Isobel Allen

There’s a lot of criticism from doctors that they are expected to work these very long hours. Some of them said that nurses manage to have shifts, why can’t we in the same kind of way? But it is part of the

continuity of care, it's part of the culture, part of what some of them call the myth – you've got to do it that way because it's always been done that way. Otherwise you don't have continuity of care.

Linda Hantrais

You named the question of whether there was a much wider issue about the counselling and advice given to doctors. It seems to me that counselling and advice is not normally available for other professions either. There's very little advice for women on how best to organise their own career structure in order to take account of what's going to happen to them later. I don't know to what extent within all professions there is advice available. It's certainly something that you're advised not to raise at interviews.

Isobel Allen

I was talking about counselling and advice for doctors in general and then went on to ask about specific advice for women. It did seem to be very limited for everybody. But again if you make it better for everybody, then you actually have to look at what you're advising. What is the point of improving the careers advice unless you do something about the career structure? Because in fact the advice to a woman would be: don't marry a doctor, get into general practice as soon as possible and don't ever consider hospital medicine, particularly surgery. If that happens and 2 per cent of consultants are women and 50 per cent of people coming out are women, what is going to happen to surgery? A lot of second rate doctors or not enough.

Liz Bargh

I think the whole area that you've raised about careers advice and counselling in schools and through university, higher education generally and beyond is absolutely fundamental because certainly in our unit's work we are constantly hearing the cry from women that they haven't had sufficient advice, they haven't had relevant advice and they haven't in any way prepared for what is actually available or what is going to be involved. I see highlighted in your study things that I see reflected right across a wide range of professions.

Heather Joshi

We were talking about the exceptionally long hours that are expected in the first stage of a professional career particularly for doctors. These expectations and standards of complete dedication were developed and were slightly more feasible in a world where you could expect the young professional to be male and to be married and to be part of a one-earner family and to have a spouse who looked after the children and the house and all the administration. It is no longer feasible when you've got two people in the household with two careers.

Susan McRae

In the United States, they're all working 80 hours a week and going jogging at 6 am in order to have their breakfast meetings at 7 am. It's a constant treadmill.

Liz Bargh

And I have to say too that there are a lot of women willing to perpetuate that way of living here. This is one of the sad things about wanting to be a success.

Heather Joshi

And they don't want to believe that they're going to be the one in three that's not going to stay married.

Nigel Meager

About the policies and what can be done, I was interested in your finding about job-share and part-time work. There would seem to be great enthusiasm for it coupled with a lack of awareness about the organisation and practical issues involved. It's interesting because it's mirrored on the organisational side. We've just started a project looking at the potential for job-share and related practices in health services generally, not just for doctors, and I was surprised at the outset by the enthusiasm that there seemed to be among a wide range of managers, personnel managers, line managers, general managers. But there was a similar groping in the dark when it came to the practicalities of doing it. But it seems that attitudes are shifting and there's a surprising willingness to look at alternatives and not take structures for granted.

Peter Moss

I'm still interested in the discussion that was going on earlier about men and women in that situation, the consensus seems to be that men are now a little more dissatisfied. Assuming that is the case, I'm interested in when and how that may seep through into changes in behaviour. In your 1981 cohorts, if the women are still going part-time but men aren't, are the male doctors talking about why they aren't going part-time? Is it purely a question of financial imperative or are there other factors? Can't men change the sources of their dissatisfaction by actually changing what they do?

Isobel Allen

I think when the chips are down the reality of life comes in, and if you see that if you go part-time you might put yourself at a disadvantage, then you're not going to do it. I think that to a certain extent the flood into general practice (which is undoubtedly happening) is a rejection of the very long hours and the very long time before you get any promotion. Some men would actually like part-time work, but it's very difficult to quantify and I wouldn't dream of attempting to do so. There were some indications among the 1981 qualifiers that they would welcome some kind of part-time work while they were trying to get their higher professional qualifications. Again it will be very interesting in the study that I'm doing now on general practice to see what the situation is. I will be asking some of those questions specifically, again both of men and of women. But unfortunately it won't be an interview, but a survey. It'll be a postal survey, with some interviews.

Patrick Walker

Following on exactly the same point, whilst I accept that there may be some differences in terms of what I'll call vocational graduates, the ones who have a feeling or think they have a feeling for a particular career among general career graduates, we're finding that more companies are telling us that more graduates on the milkround are saying to companies 'What's your equal opportunities policy like?' In other words, they are beginning to distinguish equal opportunities within an organisation's policies as being one of the determining factors as to whether they want to work in that organisation in that particular industry or in another organisation in another industry which

Keeping women in

might have a totally different culture – one based on the rat-race principle as opposed to the development and employee care principle.

Isobel Allen

But by asking that question, are they saying that they want to go to one with an equal opportunities policy? Are the men also saying that?

Patrick Walker

Yes, the men are also saying that.

Liz Bargh

Certainly that matches our experience. The organisations we deal with who are very up-front about their equal opportunities policies definitely appear to benefit in terms of recruitment, both in terms of numbers and in quality, in terms of picking the best.

Shirley Dex

You stressed what seems to be a relevant factor to medicine and other areas like academia and the public sector and that is the tightening of resources in the 1980s and the lack of opportunities that there are for people to make progress upwards compared to when the economy was expanding.

Isobel Allen

That went right through the whole thing. They were looking forward with pessimism the whole time because of the tightening job opportunities and all years of qualifiers agreed on that.

Shirley Dex

There is a real over-supply of doctors happening now in hospitals and in general practice through a shift in behaviour changes.

Isobel Allen

It's not a question of over-supply. It's a question of the balance and that's something that I haven't talked about at all. There's a whole policy, a document on achieving a balance and it's this constant imbalance which has been there for 30 or 40 years between the number of consultants and the number of juniors. This has been exacerbated by the decrease in the number of overseas qualified doctors and that's

another reason why it's going to get worse. It's very complicated but I don't think anyone could call it really an over-supply of doctors – it's the balance and they are attempting to do something about that.