Getting in and getting on in medical careers: how the rules of the game are gendered

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This paper examines discourses about medical careers through the lens of gender. The supposed feminization of medicine has prompted much professional and public discourse on the issue of gender and medical careers. Discourses centered on gender imbalance at entry to medical school are contrasted with women’s accounts of their medical careers. Data consists of both primary (24 interviews with senior female doctors) and secondary sources (national press reports, interviews, records of speeches etc.) drawn from Ireland and the United Kingdom. From the data, we explore what is seen as a problem in terms of gender and medical careers and what is not, how problems are discussed (in individual or systemic terms), and thus what changes are legitimized. We discuss the consequences of this for women in medicine and medical careers more broadly.

Key words
Gender, feminization, occupations, medical careers, entry to medical school, discrimination, women in medicine

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Introduction

Language matters, how we frame a problem in our discourse—indeed if it is discussed as a problem at all—shapes our subsequent action. To that end, our aim in this paper is to examine discourses around gender and medical careers. We look at discourses about entry to medical school and later female progression (or the lack thereof) in medical careers. We examine how important gatekeepers talk about gender and medicine. In contrast, in what ways (if at all) do women in medicine see gender and gender relations impacting on their work and progression in their careers? What does this tell us about the way gender is constructed and enacted in medical environments? The Irish situation is particularly interesting as the recent introduction of the Health Professions Admissions Test (HPAT) in 2009 as part of the screening for entry to medical school prompted debate about gender balance issues in medicine. We take the unsolicited discourses that were generated on this issue (from newspaper reports, opinion pieces, commentary in medical websites and journals, etc.) and contrast them with those used by female medics as they describe their personal journeys through the labyrinth (Eagly and Carli 2007) of medical careers. We examine what is portrayed as a problem, and what is not. We pay particular attention to how issues are diagnosed and, therefore, what is recommended as a remedy.

Following in the tradition of Acker’s (2006) work on inequality regimes, our work examines how gender imbalance in one occupation is framed very differently by stakeholders depending on whether it is males or females who are perceived to be under-represented. Our data explores how increasing feminization in the profession is explicitly labeled as a risk and threat yet masculinization is the unquestioned norm. Such discourse is potently laced with ideal worker norms, the subtext of which suggests that women do not progress as far, or as fast, as their male counterparts not because of active discrimination, but because they are not as committed as men.

Ridgeway suggests that gender is almost always a background identity and as such, “gender typically acts to bias in gendered directions the performance of behaviors undertaken in the name of more concrete, foregrounded organizational roles or identities. . . . Thus, gender becomes a way of acting like a doctor or of driving a car” (2009:10). We show how being female is foregrounded as a threat and a problem, in many ways divorced from the realities of how female medics actually do gender (West and Zimmerman 2009) in their chosen profession. This is interwoven with a background gendered identity of the ideal medic, who is one hundred percent committed to the profession, thus allowing less blatant but still pervasive questioning of the legitimacy of female medics. Thus, the background identity process of being and becoming a medic is a gendered process. It assumes the norm of a “carefree” unencumbered existence, of a worker who can put the job first at all times and at all career points. Our analysis interweaves micro (personal) and macro (public) discursive resources on gender and medical careers. In so doing, we address calls such as from Sullivan (2004) and Ridgeway (2009) that to fully understand how gender is done one ought to pay attention not only to structuring ideologies and discourses, but also “daily interactive processes . . . as described by actors themselves” (Ridgeway 2009:4). Thus, we hope, our empirical approach blends both structural and micro-interactional levels.

Our work adds to the dialogue about how gender is done, and patterns of inequality reproduced, in the professions (Bagilhole 2002; Bagilhole and Goode 2001; Bolton and Muzio 2008; Irvine and Vermilya 2010). Our contribution is to draw
attention to stark (gendered) inconsistencies in discourses about male disadvantage (at entry) and female disadvantage (in attaining career progression) in medical careers. From this we critically assess claims about the feminization of medicine. We also assess how there may be glimpses of challenges to the status quo via the re-doing of gender in medicine.

In recent years, there has been a flurry of media and professional interest in the supposed feminization of medicine. For example, in 1984, 45 percent of medical undergraduates in Ireland were female, and by 1996 this proportion had increased to 57 percent (McDonough et al. 2000). The chief medical officer (CMO) in the United Kingdom (Department of Health, United Kingdom, 2006) reported that about 60 percent of new medical students are women. This gender imbalance in entry to medical school has provoked concerns about the future of the profession (Black 2004; McKinstry 2008; Dacre 2011).

On the subject of gender (im)balance in medicine, a wholly different picture emerges at the higher rungs of the career ladder. Recent data from the central statistics office (CSO) in Ireland showed that women make up the majority of many grades in the health service, “accounting for 91.9 percent of nurses, 85.3 percent of managers and administrators, and 83.7 percent of health and social care professionals. However, in the medical/dental-consultant category women were in the minority, accounting for over one in three consultants” (CSO 2011:53).

Women have been entering medical school in significant numbers since the 1980s, yet over 30 years later are still not progressing through to more senior positions in any balanced way. Thus, the feminization of medicine appears to be restricted to the early stages of medical careers. Figure 1 summarizes the proportions of females at various levels of specialist training in hospital specialties.

**Figure 1. Male : female ratios at various levels of hospital specialist training in Ireland 2011/12**

(Source HSE and Medical Council)
As is evident from this figure, an imbalance in favor of women at entry steadily seeps away across the career path resulting in just one third of doctors at specialist level being female. Ireland is not, of course, unique when it comes to the phenomenon of gender inequality at the higher echelons of the medical profession. In the United Kingdom, less than 30 percent of consultants and 11 percent of professors are women (Department of Health 2006). Similarly, Sandhu and colleagues (2007), in a review of workforce data within academic medicine (for 2004 to 2005), identified that only one in ten medical clinical professors in the United Kingdom were women.

Previously, it was felt that once women entered professional careers in significant numbers they would “catch up” over time in terms of representation. Decades later, the effect of this changing demographic at undergraduate level should be evident at senior clinical and academic levels. This has not happened, fuelling speculation about possible barriers and discrimination. Research in the United Kingdom suggests that while some disparity at senior levels can be attributed to historical cohort trends (i.e., in the past, lower numbers of women entered medical school), “disproportionate promotion does occur at some stages in hospital medicine . . . and, as it is not easily explained as a result of differential choice, then it probably results from direct or indirect discrimination” (McManus and Sproston 2000:14).

While few dispute that there are differential gender outcomes in medical careers, far more controversial are the reasons given to explain such disparity and therefore what should or could be done about it.

If one has misdiagnosed a problem, then one is unlikely to prescribe an effective cure. This is the situation regarding the scarcity of women in top leadership. Because people with the best of intentions have misread the symptoms, the solutions that managers are investing in are not making enough of a difference (Eagly and Carli 2007).

The dearth of women at higher professional levels is only likely to be effectively addressed if (1) it is seen as a problem, and (2) following Eagly and Carli (2007), that one understands the root causes of the problem. As highlighted recently by a 2009 Economic and Social Research Institute report, differential gender outcomes are likely to be caused by a range of interacting factors including, “employer discrimination, institutional discrimination, preferences, expected sanctions, and labor force commitment” (Russell et al. 2009:49). Indeed, the CMO in the United Kingdom points to the fact that a “purely quantitative assessment does not shed light on the reality” (Department of Health, United Kingdom 2006:52). Eagly and Carli (2007) have proposed the metaphor of the labyrinth to encapsulate the twists, turns, and barriers encountered by women in their careers. The value of this metaphor is that—unlike the image of a glass ceiling, which implies a transparent obstacle which is only encountered when seeking highest office—it “conveys the idea of a complex journey towards a goal worth striving for” (Eagly and Carli 2007:64). It is useful for us to use this metaphor as we examine the twists and turns in medical careers, many of which are not subtle and may be encountered at the early stages of one’s career.

**Methods**

Our data consists of both primary and secondary texts which address the issues of getting into and getting on in medical careers. We analyze both solicited discourse (primary interviews conducted by one of the authors and analyzed independently by
three authors) and unsolicited discourse (generated by others in the form of opinion pieces, responses to journalists questions, forewords in government reports, etc.). We feel there is a complementarity between the “view from above” represented by those gatekeepers in the secondary sources with those of female medics immersed in the system, from whose interviews the primary texts were generated.

**Primary texts**

A series of semi-structured interviews were conducted with female hospital consultants in hospital sites affiliated with the University College Cork Medical School. Initially, all eligible participants were identified. As psychiatry and medicine were over-represented, hospital consultants of similar age groups in these specialties and subspecialties were randomly excluded, as the intention was to interview candidates across a range of age groups and specialties.

Interview questions were developed and agreed upon by two of the authors. There were 24 interviews in total, each lasting from 45 to 75 minutes. All interviews were recorded, transcribed, coded, assigned numbers to protect anonymity, and analyzed independently by three of the authors. We compared interviewees’ accounts both in terms of the substance of what people had to say about their lived experience of their careers to date, and in terms of the language they used and the manner in which they constructed issues of gender, merit, hard work, potential changes, and so on. For this paper, quotes were selected which were felt to be both illustrative and representative. We present findings from our interviews in a thematic manner.

**Secondary texts**

The secondary texts were drawn from a sample of Irish and UK newspapers (print and online editions), professional magazines, and letters, opinion pages, and symposia reviews from medical journals. Sources drawn on include: the *Independent* (Ireland), the *Irish Times*, transcripts of Dáil Eireann debates, the *Irish Medical Times*, CareersPortal.ie, MedicalIndependent.ie, and the *Irish Medical News*. Most pieces appeared between 2009 and 2011. The initial sample was generated through a web search for all instances of articles discussing the introduction of the HPAT in Ireland. The relevance of HPAT being that it was introduced (in 2009) as part of the system for selection to medical school. Thus, its introduction generated interesting discussions about who gets in to medical school in Ireland and how that changed following HPAT’s first use (from a 60:40 female to male ratio to 52:48 female to male ratio). Within that sample, all gender-related quotes and opinions were compiled. Of note is that many of these discourses were generated as contributors wrote or spoke in general about the pros and cons of the new HPAT in the Irish system. In that context, people’s views of a change in the male to female ratio on foot of the introduction of HPAT emerged. Later, the web search was extended to include opinion pieces, letters pages, and symposia reviews in publications such as the *Lancet*, *British Medical Journal*, the BBC (online), the *Independent* (United Kingdom), and Department of Health (United Kingdom) reports. This was done via a search for terms such as “feminization of medicine,” “women in medicine,” or “gender balance and medicine.” This extended search was not as exhaustive as the one carried out on HPAT articles but was done to examine the differences and/or similarities in Irish and UK gatekeepers’ discourses around the growing numbers of women entering medical training.
The limitation of our sample is that not every article that deals with greater numbers of women entering medicine within the given time period may have been found, so it could be said that our sample represents a partial view. However, given the sources searched and the key positions held by those whose discourse we draw on (professors of medical education, CMOs, etc.), they are undoubtedly influential.

Our analysis follows the discourse analytic traditions outlined by Burr (1995), Potter and Wetherell (1987), and Edley and Wetherell (2008). Therefore, we focus on what gender constructions emerge from subjects’ discourses and what action orientations are created through such constructions. From that perspective, we see particular value in drawing on both personal (primary interview data) and public (secondary texts) discourses to understand how gender issues might operate in medical careers.

**Diagnosing the issues: getting into medicine**

Professor Carol Black (president of the Royal College of Physicians, United Kingdom) caused quite a stir in 2004 when she alluded to the threat faced by the medical profession due to increasing female participation.

I would like to see equal numbers of male and female doctors. The women admitted to medical school do well, they work well, and they graduate well. The distinctions go to the women. But then, as the years go on, they start to make choices to balance their family and their lifestyle. . . . What worries me is who is going to be the professor of cardiology in the future? *(Independent* 2004).

The headline for the piece leaves little room to doubt the sense of perceived risk: “The Medical Time Bomb: Too Many Women Doctors.” Note in her comments that her ideal notion of gender balance is followed by “But . . . they start to make choices.” Therefore, while ideally gender balance would be achieved, it is seen as stymied by the choices women make. Clearly, the rising number of females entering medicine is seen as problematic in some way. Concerns about the feminization of medicine are echoed in BBC (online) taglines such as “Women Docs ‘Weakening’ Medicine” (2004) and “Rise in Women Doctors ‘Worrying’” (2008).

Dacre (2011), based on data from the Royal College of Physicians, predicted that women would outnumber men in the medical profession by 2017 (or 2013 for GPs). McKinstry, in a piece entitled, “Are There Too Many Female Medical Graduates? Yes” makes reference also to the “time bomb” of increasing female participation in medical training and profession. His solution is as follows:

However, in the absence of a profound change in our society in terms of responsibility for child care, we need to take a *balanced approach* to recruitment in the interests of both equity and future delivery of services (McKinstry 2008; our emphasis).

The implication being that more men should enter medical training, rather than, for example, working conditions or organizational structures changing. This response to the perceived “threat” of the feminization of medicine was echoed in “Welcome for More Men Doing Medicine: Medical Schools Pleased by Return of Gender Balance” *(Irish Times* August 18, 2009).
Professor of academic medicine and director of undergraduate teaching and learning at Trinity College, Dublin, Professor Seán McCann, said one of the aims of changing the entry system to medical school was to adjust the gender balance, “from the [medical] profession’s point of view, a fifty-fifty mix is desirable,” he said.

Foundation head of the graduate entry medical school at the University of Limerick, Professor Paul Finucane, said: “The pendulum had swung too far in favor of females. It’s important we have a system that doesn’t disadvantage males in the way that, 40 to 50 years ago, it disadvantaged females” (Irish Times, August 18, 2009; our emphasis).

It seems clear from this discourse that the increasing female entry to medical education was/is seen as problematic by at least some influential gatekeepers in medical education. Take note of the remedies suggested: a change to recruitment policy and/or practices, a change to medical school entry, changing a system that “may disadvantage males.” So, to avoid possible disadvantage to one gender, to re-balance ratios, to create fifty-fifty ratios, the solutions are discussed in systemic terms. An alternative discourse might have centered on individual choices and/or efforts, for example, to encourage males to work harder at examinations, to make different choices regarding time spent at sport versus study, and so on. Interestingly, a review carried out by Kilminster et al. (2007) suggests that one possible reason for male decline in entry to medical school may not, in fact, be due to male underachievement at examinations, or that the entry tests disadvantage males in some way, but because men are choosing to enter more lucrative professions such as business, law, and information technology.

Our interviewees also commented on the issue of gender balance in accessing the first rung of a medical career, for example:
I have ambivalent feelings about this, the ratio of doctors needs to represent the population, really. In years gone by, it was all male doctors and that was wrong, and in the future it will be all females and that’s wrong. I think it should move more towards a balance but also it’s unfair for women being discriminated against, we’ve just reached the goal posts and they are being moved again. [Interviewee eight]

Most interviewees valued the notion of gender balance in access to medical education. The perceived threat of “too many females” is also echoed in their discourse; however, they questioned (1) the fairness of entry requirements being changed when women excelled at them, and (2) whether “too many females” was the problem, or whether there was instead a need to “change the job.” Changes here were usually cast as systemic organizational/job design issues, such as decreasing the incredibly long working hours expected in the job. The following quote from the general secretary of the Royal College of General Practitioners appears to echo our interviewees’ views that there is a need to change workforce planning and practices:
But the CMO’s report makes it clear that if you know about people’s career needs you should be able to plan for them. So, you should be able to prepare for the fact that some of your workforce might have to take a couple of maternity leaves, and avoid wasting women’s potential (Oxtoby 2009).

This section established the existence of a discourse centred around the feminization of medicine, the associated risks or threats this is thought to pose to the system, and finally the remedy being posited by some influential gatekeepers as one of
actively changing the recruitment/education system to re-balance gender (in favor of males) at career-entry stage.

**Getting on in medicine: doctors differ and careers die**

In contrast, how do female medics talk about their experiences of a medical career? Have they experienced discrimination, what opportunities and challenges have they encountered in their careers thus far, and to what extent are these gendered experiences? The image and language of a glass ceiling that women bump up against is a pervasive one. However, is this an accurate representation of medics’ experiences or do they encounter the labyrinth? Are their experiences gendered from entry to the career and not just when seeking highest office?

**Experience of overt discrimination: early steps in the labyrinth**

Stratton and colleagues examined the role of gender discrimination and sexual harassment in US medical students’ choice of specialty and residency program. The overwhelming majority of men (83.2 percent) and women (92.8 percent) surveyed reported experiencing, observing, or hearing about at least one incident of gender discrimination or sexual harassment during medical school.

Across all specialties, more women than men experienced gender discrimination and sexual harassment during residency selection, with one exception: a larger percentage of men choosing obstetrics and gynecology experienced such behavior. Among women, those choosing general surgery were most likely to experience gender discrimination and sexual harassment during residency selection (Stratton et al. 2005:400).

Their research highlights the unfortunate prevalence of discrimination in medical training and selection for residency. It is noteworthy that women opting for general surgery seemed to be most likely to experience discrimination and this may illuminate data from the United Kingdom’s CMO, that less than ten percent of surgical consultants are women (Department of Health, United Kingdom 2006:52).

Interestingly, men also experience discrimination when opting for a non-stereotypical choice. Four of the 24 interviewees described overt discrimination at interview, for example:

At that stage, I sat through one interview for a registrar post and it would be illegal today. The only question I was asked, I was pregnant at the time, and I was asked did I have a locum arranged for the place of SpR [specialist/senior registrar]. And wasn’t given that job because I told them I was pregnant . . . and both professors apologized at the time but I still didn’t get it. And that would have had to be reported at the time. It was very inappropriate. [Interviewee 14]

While these women’s experiences are quite shocking, what was much more common was for interviewees to report that discrimination (in terms of clearly illegal practices) had not happened, but that less overt, more subtle, forms of discrimination occurred, such as:

I’d say it’s probably a little bit more difficult [speaking of her training] because there are a few consultants who are of the old school who like the guys who play football and go drinking. So it makes them more likely to select the male SpRs to train with them. [Interviewee 12]
No, because it’s illegal but you’re checked out beforehand and people ask subtle questions about where you are with your family. . . . I’ve never found discrimination, I have to say, but that’s because I assumed a male role in commitment. [Interviewee eight]

When asked if she ever took time out, one interviewee said, “maternity, six weeks, never took any other time out. On interview level it’s always a question why you took time out.” [Interviewee 18]

Thus, we see more subtle forms of discrimination emerging where a female is not openly discounted because of her gender per se, but because she may “take time out” or not exhibit a “male role in commitment,” combined with homosociability in terms of male medics feeling more comfortable around other males. The subtext of the discourse is of a feminine lack (Bendl 2008) in relation to male norms. Interviewee eight’s comment echoes Cockburn (1991:161), “if women want to be equal they must abandon any idea of ‘difference.’” Bear in mind also that our interviewees are those who are still in the labyrinth of a medical career. It would be interesting to follow up with those who have withdrawn to see if they report—or were less accepting of, or resilient about—higher levels of discrimination. For many of our interviewees, their choice of career path was based on interest in a specialty.

Interest, it wasn’t because I thought it would be a good career for a woman. [Interviewee eight]

It wasn’t the lifestyle, I was always going to do general medicine and then during my placement as an undergraduate, I really liked it and switched. So really, it was interest, the lifestyle and training, I was ignorant of that. [Interviewee 15]

In contrast, we found some interviewees who considered job demands when choosing specialties.

Changed from medicine to [another discipline] suited me better because it’s more academic. Also, lifestyle, though, especially with my husband in medicine, too, one of us needed a job more amenable to family life. Did think about paediatrics for a while but the hours are too long. [Interviewee three]

I was interested in obstetrics and I decided that a life as a consultant obstetrician wouldn’t give me the lifestyle I aspired to, in terms of family life. [Interviewee six]

Women who choose specialties that are perceived to be more “family friendly” are probably guided by a realistic appraisal of the difficulties of balancing job demands with non-work demands. Their choices, however, are again not acontextual. For example, Helen Fernandes (a consultant neurosurgeon at Addenbrooke’s Hospital, Cambridge, and chair of the national body Women in Surgery) says that although some female surgeons might be well supported, others may come across a mentor who will tell them it is impossible to be a surgeon and have a family; as Fernandes points out, “when you’re young and impressionable this can be a very destructive experience” (cited in Oxtoby 2009).

This early effect of a gendered labyrinth for medical careers is borne out by Kilminster et al.’s (2007) review of studies examining the culture and practice of
medicine. They found no consistent evidence of enduring differences between males and females in terms of career motivation, academic performance, or clinical skills and experience. There did, however, appear to be quite a weight of evidence suggesting that both medical culture and societal culture (e.g., in terms of patient preferences and expectations) is quite gendered, in that there were differing expectations about male and female trainees and doctors from educators, colleagues, and patients.

Thus, we can see that the gendering of careers occurs from the earliest stages in the labyrinth and not just when female medics aspire to the most senior positions. As we have illustrated in this section, in some cases, female medics encounter quite blatant discrimination, while others encounter more subtle forms. Some of our interviewees shape their career strategies solely based on occupational interests, and others base theirs on a mix of interest and work-life balance concerns. In all cases, however, interviewees acknowledged the very high job demands in the medical sphere.

Being the ideal worker

A medical career is portrayed by all as requiring very high levels of commitment, investment of time (both in training and work demands), and carrying responsibility. On the theme of questioning women’s commitment to medical careers, VanderBrink (2011), in an in-depth study of the practices around professorial appointments in academic medicine, found that women candidates tend to be overlooked due to three gendered practices: (1) exclusive network practices (amongst male networks), which relates to our earlier point about homosociability in medicine; (2) perceptions that women are “other” or different in terms of levels of commitment; and (3) gender stereotypes about leadership style.

In relation to perceptions that women are “other” in terms of commitment levels, some of our interviewees were aware of this perception and responded by “working harder so no one could say you’re slacking off because you’re female” [Interviewee one].

Many (17 out of the 24 interviewees) mentioned marriage and/or children as making the training/career path more difficult for women. I do think it has an influence because people make lifestyle decisions if they have young children, they make a decision that they need to give more attention to their family than their career. Women make those decisions themselves. . . . The environment doesn’t help, not because of active discrimination, but it’s not family friendly. [Interviewee eight]

Of course, individuals (male or female) make personal choices and decisions about the manner in which they juggle work and non-work activities. However, what is interesting here is the way this is framed—not giving your all to a career is a “lifestyle decision,” rather than a normal response. Note that “women make those decisions themselves,” so it’s not seen as something men struggle with, and the decision is portrayed as an individual accommodation rather than a systemic shortcoming. Other interviewees echo the discourse of “choice” and women’s family-oriented choices. Absolutely [gender did impact on training], not so much by being a woman but by making family-orientated choices . . . It wasn’t being a woman but being a mother that made the subsequent training difficult or challenging. [Interviewee 15]
Women and men consultants have very different lives. I think all women are double jobbing. The men don’t mind the meetings at five or six o’clock, actually they’re happy because then the children are in bed when they get home. The majority, not all, don’t mind it. [Interviewee 21]

Interviewee fifteen’s comment that it’s not “so much by being a woman but by making family-orientated choices” highlights the manner in which discourse has shifted from questioning women’s ability or merit to their commitment. The implication being that if individuals made different choices (i.e., to be seen to prioritize career at all times and life stages), then there wouldn’t be an issue. Alternatively, one could recommend a shift in job demands and perceptions of commitment. For example, Beryl De Souza, joint honorary secretary of the Medical Women’s Federation, hopes that better access to more flexible training and part-time work options would “help to overcome perceptions that those in part-time work or who are training part time only have a part-time commitment to medicine” (cited in Oxtoby 2009).

It is clear that the ideal worker archetype is very strong in medicine. Female medics may choose to work even harder (than male colleagues) in an attempt to overcome negative gendered perceptions of their commitment, or to attempt to balance work and life commitments as best they can, however all act in an organizational climate which is decidedly “chilly” for those who do not meet the profession’s expectations of one hundred percent commitment. As we will illustrate in the following section, there are serious consequences for those who do attempt to conform to such expectations.

Consequences of staying in the labyrinth

It is fair to say that all our interviewees recounted how their career has had significant impacts on themselves and their families. It is important to note that the vast majority loved their work and were very interested in it, however most were not content with their work-life balance, feeling that they worked far too much. Quite a number of interviewees spoke about delaying having children, deciding not to have children, or having fewer children due to the demands of training and/or work.

I delayed having my children until I was appointed consultant. I was in my late thirties when I had them. Work certainly affected that. [Interviewee seven]

If I wasn’t working as a full-time [position] . . . I would have had more children. [Interviewee six]

I was very committed but I think now, I regret not giving more time to my family. . . . I was never at a parent-teacher meeting, never at a school concert, never at a sporting event. I’d say they missed out because I was at work all the time. [Interviewee one]

Totally unhappy [with work-life balance], I have sacrificed my family to my career, totally. I’d say most consultants have it completely wrong, devote themselves to their career, which is wrong. [Interviewee eight]

Thus, while public discourses recounted in a previous section blatantly label women as a threat to the profession, it would seem that in medics’ day-to-day
experiences, the key threat is to their personal well-being and their time with family. A number of our interviewees mentioned good support systems as being crucial in order to square the circle of high job demands and family demands. In every case, however, any supports that are discussed are available in the personal/domestic sphere only; supports are not available in the work organization. Domestic support is bought (subcontracting childcare/domestic work) or sought: “we’d all love wives” [Interviewee two]; “If I didn’t have her [the nanny], then it would be impossible” [Interviewee four].

A smaller subset of interviewees (five) had atypical domestic arrangements, for example:

There were lifestyle changes to allow me to continue on as a consultant, my husband made them, he works part time now, so that I can carry on as full time. I think it would be impossible if we hadn’t made that arrangement. [Interviewee eight]

In contrast to good domestic support, there was a strong sense that organizations do not support any form of flexibility or outside life. For example, many interviewees mentioned the career drawbacks of being part time yet no decrease in the workload.

“There’s no cover at all”

In the interviewees’ accounts, those who cut back or leave particular careers are represented as doing it for family/lifestyle reasons—not because they weren’t capable or interested in medical careers. The interviewees all stayed the course, but many have regrets or have made sacrifices for their careers. No one’s account suggests that it is easy or indeed even possible to continue full time in a medical career without significant personal and family sacrifice.

We have seen in our interviewees’ accounts examples of both overt and indirect discrimination, a sense of the challenges faced, and personal sacrifices made, by female medicos both when embarking on medical training and when progressing in their careers, the importance of domestic supports and the stark absence of organizational supports. Indeed, the chilly organizational climate is noted for those who deviate from the traditional male career path of long hours and unbroken service.

Re-designing the labyrinth: what are the trajectories for change in medical career paths?

What changes (gender related or other) are seen as either desirable or possible by our sample? The key changes discussed were job sharing, including “more team-based” work [Interviewee three] and a curtailment of working hours.

I think what we need is the possibility of job sharing and the possibility of a more family-friendly working life. [Interviewee four]

Administrators don’t work overtime unless you pay them, why should doctors and junior doctors do it, they shouldn’t be put under that pressure. If they have to employ more and do a shift system and job share, well I’d prefer to have a doctor who’s fresh and interested if I came into A&E, than one who’s worked 30 hours. [Interviewee 14]
Other suggestions included more acceptance of alternative career models, for example, part-time work and reduction in work intensity and job demands, as the following quote illustrates:

I’d facilitate more people working part time at various stages of their career, not necessarily females, some men, too, if they wished, at critical points of their careers. [Interviewee seven]

Note from Interviewee seven’s comments that such changes are not limited to one gender but aimed at improving work-life balance for both genders, and indeed in many interviewees’ accounts, also improving the quality of service provided to patients. Most of the changes suggested were framed in systemic terms, for example, changing work design/demands, organizational structures, and supports.

If such changes would be welcomed by the medics in our sample, what then do they see as the potential drivers of change in the system?

Will it change? Definitely, if it goes more female, because women have children, the service has to recognize that and do something, not just say ‘that’s terrible’; they’ll have to recruit more people. I think that in the future, males won’t want to work as many hours either, there’s a change afoot, the service needs to recognize that at a human resource level and they’ll have to recruit more people. . . . There’s got to be acceptance. [Interviewee eight]

Most interviewees recognized that changes were more likely to happen if sought by both male and female medics. These issues are also recognized by Sir Bernard Ribeiro (former president of the Royal College of Surgeons); he recalls how years ago there was a saying that summed up a male surgeon’s list of priorities: knife, wife, and life. “Now it’s changed to life, wife, and knife,” he says. With women and men in the profession demanding more from life than solely a career, he says, “we need to create a workplace that makes it easier for people to progress and to support those who have children to be able to work flexibly (cited in Oxtoby 2009).

There is a sense from our interviews that many women would like changes to their work-life balance, yet only see change as possible if systemic changes occur. This is primarily due to the perception that to opt for an alternative path is career suicide. As Interviewee eight said, she would “not be able to progress as far as I have done” if she had gone part time.

I think it’s difficult; a lot of my friends when I was training were working part time and felt very undervalued. They were really working three quarters the hours rather than half and could see no end in sight. I think that the system under values part-time work and as an individual, you need to be very robust for that. [Interviewee six]

As is evident in the interviewee extracts about desired changes, the impetus to change was seen as stemming from new forms of consultant contracts (in Ireland), and more staff (both men and women) wanting a different lifestyle. It seems clear that the system will only change if forced to (i.e., staff shortages and a consequent need to keep female doctors in the workplace), not because it’s the right thing to do. This is in stark contrast to discourses around not allowing the system to “disadvantage males” at entry to medical school.
Discussion

One could argue that instead of “individual choice”—which implies a contextual prioritization of family over work, linked to stereotypical assumptions about what women should do—the data here shows constrained choices, or to use another term, adaptive preferences.

Deprived groups often develop adaptive preferences: they lower their demands and sights, proscribed by the narrow experiences shaped by the mechanisms of disadvantage. In a gender context, the argument might be that women become ‘stuck’ at middle management levels because of organizational constraints and practices that discriminate against women (Cornelius and Skinner 2008:143).

Thus, it could be argued that women do not choose to prioritize family over work in a value-free environment but rather in the expectation that advancement to senior levels is beyond their reach due to discriminatory organizational practices. It is easy to dismiss concerns about women’s lack of progression if one attributes it to acontextual “individual lifestyle choices.” However, if such choices stem from adaptive preferences shaped in the context of expectations of both work and home life, then it opens up the possibility again of having to adapt a system rather than an individual choice. The concept of adaptive preference fits with the accounts provided by our interviewees where subtle (and sometimes blatant) institutional discrimination was part of their work experience. It also lends weight to Eagly and Carli’s (2007) representation of the labyrinth of gendered experiences at work. Interestingly, recent research by Silva and Carter (2011) on male and female MBA graduates from prestigious business schools tested the theory that women’s lack of progression was due to their “lifestyle” choices (rather than a chilly organizational climate for women). They found that in the subset of men and women who explicitly aspired to become CEO and who did not have children, women lagged behind men from day one. Such findings were also described by Ash et al. (2004) who conducted a large scale comparison of almost 2,000 medical school faculty members in 24 medical schools in the United States. Their work showed a rank and salary disparity between male and female faculty. However, the more interesting finding from their work was that such disparities persisted even when they controlled for a wide range of professional characteristics and achievements, including number of publications, years of seniority, hours worked, department type, and so on. Thus, our analysis of female medics’ career paths lends further support to the literature outlining the pervasive nature of explicit and implicit forms of discrimination that still form part of the career experiences of professional women.

The second key issue to address from our analysis is whose values and choices are embedded and respected within institutional practices, and whose are not. For example:

- A 60:40 (female to male) ratio imbalance at entry to medical school prompts some key gatekeepers to call for a change in the system, indeed to speak about a “medical time bomb.” However, a 70:30 (male to female) ratio at consultant level in Ireland apparently does not provoke the same impetus to change. Nor does it produce startling headlines expressing concerns about the “masculinization of medicine.”
- Discourse no longer questions female merit or ability (female academic achievements provide clear evidence to the contrary), but more subtly, women’s commitment is now questioned. If one can’t give one hundred percent to a medical career, at all stages of life, then that is used as explanation for women leaving the profession or not progressing as far or as fast as their male
counterparts. This discourse situates the problem with females and thus the remedy is for them to change, not the system.

However, there is growing evidence from research that both genders have some interest in changing the status quo. For example, Dorsey and colleagues (2005) reported that “the percentage of women choosing specialties with controllable lifestyles increased from 18 percent in 1996 to 36 percent in 2003. For men, the percentage grew by a similar amount from 28 percent to 45 percent.”

Also, Heiligers et al. (2000) found that 50 percent of their sample of male and female specialists in the Netherlands expressed a preference for part-time hours. The sense that norms will only change if both genders re-prioritize work and family was echoed by many of our interviewees.

Our qualitative analysis of female medics’ experiences of their training and careers addresses the call by Kilminster et al. (2007) that to fully understand the impact of gender on training and careers one would need detailed accounts of medics’ experiences of gender on their career paths. Gender is still clearly an issue for the medical profession. However, the focus has changed from overt discrimination against women to more subtle forms that question women’s commitment to the profession. It would seem that while a proportion of women do successfully navigate the labyrinth of medical careers that they must accept and display “a male role” in order to do so.

Bolton and Muzio (2008) point out that the feminization of a professional group is not just a numerical but is also a cultural process. Thus, rising numbers of women at medical school and at the early stages of a medical career can not really be said to be “feminizing” medicine, similar to findings in relation to veterinary medicine (Irvine and Vermilya 2010). However, women—not in an essentialist fashion but through their socialization and prevailing cultural norms—may have different values around family-orientated issues. Family-orientated values are most certainly not part of the accepted discourse in relation to successful medical careers.

The issues raised are not new—nor perhaps are they unexpected. But to tackle them is going to require a steep change in how the medical workforce as a whole behaves. It will require an acceptance of alternative and differing patterns of working and training for all medical staff, not just women. Wider changes in society, such as some men choosing to become the primary child carer, mean that the recommendations in this report are proposed not just to provide opportunity to women but to offer better options to the entire medical workforce (Donaldson, CMO United Kingdom 2009:3).

Note in this extract from the United Kingdom’s CMO that “it will require an acceptance,” which implies that this acceptance is not already widespread and data from our interviewees would certainly highlight that any training or career moves departing from traditional models are seen negatively.

Currently, the system disadvantages those who seek to have some life outside medicine (at present this may particularly affect female staff). The influence of Generation X doctors and newer graduates may eventually neutralize the gender specificity in debates about work-life balance as flexible work practices are more frequently requested regardless of gender (Jovic et al. 2006).
A work practice that disproportionately disadvantages one group may be seen as indirect discrimination. For example, according to the Gender Equality Division of the Irish Department of Justice, Equality, and Law Reform (2009):

Gender equality is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including economic participation and decision making, and when the different behaviors, aspirations, and needs of women and men are equally valued and favored. (our emphasis)

This definition of gender equality raises an interesting challenge for many organizations—that is that equality is not merely about legal compliance, or equal access, or equal opportunity to compete, it is also about equally valuing different behaviors and aspirations. It is clear from our study that patterns of inequality in the medical profession will continue to be reproduced as long as only one model of becoming and being a successful medic remains dominant.

The value in our work has been to call attention once again to the continuing vertical and horizontal gender segregation in medical careers. We demonstrate how increasing numbers of women entering medical school is being perceived as a serious threat and risk to the profession, whereas their relative absence at senior levels is not. Even amongst those gatekeepers who view increasing female participation not as a risk but simply a workforce planning issue to be accommodated, their discourse highlights how this will require significant shifts in the culture and practice of medicine, thus indicating the lack of diversity in current models of medical training and careers.

References


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**Résumé**

Cet article se propose d’examiner les discours portant sur les carrières médicales, à travers la question du genre. La soi-disant féminisation du monde médical a en effet entraîné nombre de débats professionnels et publics sur le rapport entre carrière en médecine et question du genre. Pourtant, entre les inégalités d’accès en faculté de Médecine et les témoignages de femmes concernant leur carrière médicale, ces discours semblent se contredire. Notre recherche, entre l'Irlande et le Royaume-Uni, s’articule à la fois sur un travail de terrain (24 entretiens avec des femmes médecins-chefs) et sur des sources secondaires, (articles ou rapports de presse, entretiens, discours publiés, etc.). A partir de ces sources, nous problématiserons la question du genre dans les carrières médicales, nous examinerons également la façon dont les problèmes sont généralement exprimés (au niveau individuel et au niveau systémique), et les attentes de changement qui sont exprimées. Enfin, nous discuterons les conséquences de cette situation pour les femmes médecins et plus largement pour les femmes travaillant dans le milieu médical.

**Resumen**

Este artículo examina discursos sobre carreras médicas a través de una perspectiva de género. La supuesta feminización de la medicina ha resultado en discursos profesionales y públicos relacionados con la cuestión de género y carreras médicas. Contrastamos los discursos centrados en el desequilibrio de género a la entrada a la facultad de medicina, con las voces de mujeres sobre sus carreras médicas. Los datos consisten en fuentes primarias (24 entrevistas con mujeres médico) y secundarias (reportajes en periódicos nacionales, entrevistas, archivos

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de discursos etc.) de Irlanda y el Reino Unido. A través del material exploramos lo que se llega a definir como un problema de género y carreras médicas, y lo que no, cómo hablan de los problemas (en términos individuales o sistémicos), y qué cambios son legitimados. Concluimos con una discusión de las consecuencias para mujeres médico y carreras médicas en general.