The Inter-Relationship between Professional Life and Family Life: the case of Hospital Consultants in one Health Region in the United Kingdom

Submitted for the award of PhD

Carol Dumelow
October 1997

Department of Sociology
University of Surrey
Guildford
ABSTRACT

This thesis examines gender differences in the inter-relationship between professional life and family life of hospital consultants. Data generated from 202 semi-structured interviews with NHS hospital consultants aged forty to fifty years working in South Thames Region during 1995 were used to explore the relationship between a hospital medical career and family life for men and women working in different medical specialities. This thesis examines how men and women who have achieved consultant grade in Hospital Medicine have managed the relationship between their work and home life.

The relationship between a medical career and family life for hospital consultants was closely interlinked, particularly for women consultants. This was associated with the pattern of women consultants' careers in terms of horizontal segregation within specialties (i.e. more women in psychiatry and anaesthetics, less women in surgery) and vertical segregation within the consultant grade. Three types of work/family relationship adopted by consultants to manage the interface between work and family were identified. These showed that the majority of male and female consultants have 'segregated' work and family relationships, although female consultants were more likely than male consultants to have a 'career dominant' or an 'accommodating' work/family relationship. These strategies had a different outcome on family life and on involvement in professional life for male and female consultants and adoption of different strategies were strongly influenced by both domestic and organisational constraints. A 'segregated' strategy was the most successful strategy for women consultants in terms of career progression and quality of home life, but was the least
satisfactory for male consultants. Men who adopted an 'accommodating' strategy were the most satisfied with their work/family relationship, although they were less successful in their careers than men with 'segregated' work/family relationships. A 'career dominant' work/family relationship was the most successful strategy in terms of career, but least successful in terms of family life, for both male and female consultants.

Male orientated working practices and hospital medical culture had a greater detrimental effect on the family building patterns of women than men, however these factors were perceived to be detrimental to the family life of both male and female consultants. This thesis proposes that current changes to specialist medical training (Department of Health, 1993) need to be accompanied by a change in the culture, attitudes and practices in Hospital Medicine, which will benefit all doctors, not just women. These changes need to recognise that both male and female doctors have families and need time for personal and family life.
ACKNOWLEDGEMENTS

I would like to express my appreciation to Professor Sara Arber and Professor Peter Littlejohns for their advice, guidance and continuous support and encouragement while I was undertaking this thesis. I am also particularly grateful to Professor Littlejohns for giving me extra time to finish writing my thesis, while I was employed at the Health Care Evaluation Unit.

I am grateful to Dr Sian Griffiths, former Regional Director of Public Health at South Thames Regional Health Authority, for providing financial support for this project and for her support and encouragement during the early stages of this study and to Dr Mary Ann Elston for the opportunity to discuss the theoretical issues surrounding women doctors' careers which helped in forming the theoretical framework for my thesis.

I would like to thank Gillian Carey, Suzanne Cohen, Miranda Cormell and Juliet Essen for undertaking the interviews with the hospital consultants, especially for their dedication and persistence; Dr Jane Fielding for her help and advice with the graphical presentation of the work history sheets; Geraldine Barrett, for proof reading my thesis and providing some very helpful comments on my draft and Ruth Clifford for checking and reading my draft chapters.

I would like to thank my colleagues at the Health Care Evaluation Unit and the Department of Public Health Sciences for their continuous encouragement during the four years that I was undertaking my thesis, as a member of staff and a collaborative student at the University of Surrey.

Finally, I am grateful to all the consultants who took part in this study for their willingness to give up their time and for providing such rich and detailed information about their professional and personal lives.
## CONTENTS

### Abstract

### Introduction

#### Chapter 1: The Professional Life of a Hospital Doctor in the United Kingdom

1.1. Introduction
1.2. The Structure of the Medical Profession in the United Kingdom
1.3. Training to be a Hospital Consultant
   1.3.1. Part Time/Flexible Employment Opportunities
   1.3.2. The Doctor’s Retainer Scheme
   1.3.3. Changes to the Hospital Medical Career Structure
   1.3.4. The Changing Role of Hospital Consultants in the United Kingdom
1.4. Organisational Culture and the Medical Profession
   1.4.1. The Hospital Medical Career Structure
   1.4.2. Working Hours
   1.4.3. Equal Opportunities
   1.4.4. Patronage
   1.4.5. The Medical Hierarchy
1.5. Women in the Medical Workforce
   1.5.1. Speciality Choice
1.6. Gender Inequality in the Medical Hierarchy
1.7. Women in the Medical Workforce in other Western Countries
1.8. Summary

#### Chapter 2: Women’s Careers in Male Dominated Professions

2.1. Introduction
2.2. The Concept of a Career
2.3. Working Patterns in Male Dominated Professions
2.4. Women in Male Dominated Professions
2.5. Gender Segregation in Male Dominated Professions
   2.5.1. Individual Choice and Personal Preference
   2.5.2. Structural Constraints
   2.5.3. Patriarchy in Organisations
   2.5.4. Individual Choice and Structural Constraints
2.6. New Directions in Equal Opportunities Policies
2.7. Summary
Chapter 3: Family Roles of Professional Women

3.1 Introduction 71
3.2 Marriage and Parenting Patterns in the United Kingdom 71
3.3 Marriage and Parenting Patterns of Professional Women 72
  3.3.1 Dual Career Couples 74
3.4 Professional Women’s Employment Patterns Following Childbirth 77
3.5 Women Doctor’s Employment Patterns Following Childbirth 79
3.6 The Dual Roles of Professional Worker and Mother 81
3.7 Unpaid Work in the Home 85
3.8 Doctors and the Domestic Division of Labour 90
3.9 Summary 93

Chapter 4: Methods

4.1 Aim of the Research 95
4.2 Research Questions 95
4.3 Context of the Research 96
  4.3.1 Area of Medical Practice 96
  4.3.2 Age Group 98
4.4 Choice of Method 99
  4.4.1 Postal Questionnaire 99
  4.4.2 Structured Interview 100
  4.4.3 In Depth Interview 100
  4.4.4 Semi Structured Interview 101
4.5 Developing the Framework for the Research 102
  4.5.1 Qualitative Interviews 102
4.6 Geographical Location of the Research 103
4.7 Content of the Interview Schedule 106
4.8 Sampling 110
  4.8.1 Grouping of the Hospital Medical Specialities 111
  4.8.2 Choice of Sampling Method 114
  4.8.3 Sample Selection 115
4.9 Pilot Study 117
4.10 Recruitment and Training of Interviewers 118
4.11 Data Collection 119
  4.11.1 Purpose of the Curriculum Vitae 120
  4.11.2 Interviews 121
  4.11.3 Recording the Information 124
  4.11.4 Coding and Managing the Data 125
4.12 Validity and Reliability 126
  4.12.1 Validity 126
  4.12.2 Reliability 128
4.13 Methods of Analysis 129
  4.13.1 Quantitative Data Analysis Methods 129
**Chapter 8: The Gendered Relationship between Paid Work and Unpaid Work**

8.1. Domestic Labour 217  
8.2. Child Care 222  
8.3. The Gendered Effect of Family Life on a Hospital Career 229  
8.3.1. Effect of Children on Career Progress 230  
8.4. The Gendered Meaning of Work 238  
8.5. Non Traditional Career Paths 241  
8.6. Summary 251

**Chapter 9: Speciality Choice and the Relationship between Professional Life and Family Life**

9.1. Speciality Choice 254  
9.2. Managing Dual Roles of Work and Family 263  
9.3. Summary 267

**Chapter 10: The Gendered Boundaries between Professional Life and Family Life**

10.1. The Inter-Relationship between the Professional Life and the Family Life of Hospital Consultants 269  
10.1.1. Career Dominant Work/Family Relationship 272  
10.1.2. Segregated Work/Family Relationship 277  
10.1.3. Accommodating Work/Family Relationship 282  
10.2. Attitude towards the Relationship between Professional Life and Family Life 286  
10.2.1. Career Dominant Work/Family Relationship 286  
10.2.2. Accommodating Work/Family Relationship 291  
10.2.3. Segregated Work/Family Relationship 293  
10.3. Summary 299

**Chapter 11: Conclusions**

11.1. Explanations for the Pattern of Women Consultants’ Careers 303  
11.2. Types of Work/Family Relationship 309  
11.3. Gendered Outcomes of the Work/Family Relationship 311  
11.4. A Change in Hospital Medical Culture and Discourses of Time 317  
11.5. Study Limitations and Further Research 320

**Bibliography** 323
Appendices

Appendix 1 Interview guide for qualitative interviews
Appendix 2 Interview schedule
Appendix 3 Letter sent to consultants
Appendix 4 Work and life history grid
Appendix 5 Example of a chart used in qualitative data analysis
Appendix 6 Map of South Thames Health Region
Appendix 7 Addendum
### Tables

1.1. Percentage of female hospital consultants by speciality in NHS hospital in England and Wales as at September 1995  
1.2. Percentage of female doctors in selected hospital medical specialities in the U.S.A., Finland and the United Kingdom  
4.1. Proportion of acute hospitals, specialist hospitals and community hospitals by NHS Region in England and Wales in 1995  
4.2. Sampling method  
4.3. Distribution of consultants in the study sample across South Thames Health Region  
4.4. Response rate of consultants by speciality group  
5.1. Age and sex of consultants  
5.2. Mean age of consultants by speciality group  
5.3. Distribution of consultants across the South Thames Region  
5.4. Current employment status of consultants  
5.5. Mean age achieved first substantive consultant post according to speciality group  
5.6. Number of years in consultant post  
5.7. Holders of a distinction award by grade awarded as at January 1995  
5.8. Percentage of consultants with a distinction award by age as at January 1995  
5.9. Percentage of consultants with a distinction award by type of hospital as at January 1995  
5.10. Percentage of consultants who have a distinction award by medical speciality group as at January 1995  
5.11. Percentage of consultants who have a distinction award by number of years in consultant post as at January 1995  
5.12. Marital status of consultants  
5.13. Marital status of consultants by speciality group  
5.14. Grade at first marriage for hospital consultants  
5.15. Current employment status of consultant’s partner: married/cohabiting consultants  
5.16. Social class of consultant’s partner: currently married/cohabiting consultants  
5.17. Social class of consultants’ partner: divorced/separated/widowed consultants  
5.18. Occupational status of consultant’s partners  
5.19. Current occupation of consultant’s partners  
5.20. Parental status of hospital consultants  
5.21. Age of youngest child
5.22. Marital status of teaching hospital consultants 155
5.23. Marital status of female consultants according to type of hospital 156
5.24. Mean age for birth of first child according to type of hospital consultant 157
6.1. Medical grade at birth of first child 165
6.2. Family size of consultant parents 167
6.3. Perceived effect of hospital career on the family life of consultant parents 170
6.4. Perceived effect of hospital career on the family life by speciality group: consultant parents 171
7.1. Family type amongst hospital consultants 186
7.2. Current occupation of partner of consultant surgeons 187
7.3. Stage in career first child was born: consultant surgeons 188
7.4. Primary source of child care: consultant surgeons 188
7.5. Occupation of partner: dual career couples 189
7.6. Parental status: dual career couples (not dual doctor) 190
7.7. Employment status of consultant's partners in full time/part time families 194
7.8. Characteristics of lone consultant parents 201
7.9. Percentage of consultants who were dual doctor couples by medical speciality group 202
7.10. Type of dual doctor couples 203
7.11. Family structure of dual doctor couples 204
8.1. Division of household tasks amongst married/cohabiting female consultants with dependant children 219
8.2. Division of household tasks amongst married/cohabiting male consultants with dependant children 220
8.3. Division of household tasks amongst female consultants in dual career couples with dependant children 221
8.4. Division of household tasks amongst male consultants in dual career couples with dependant children 222
8.5. Primary type of child care used by consultant parents 223
8.6. Division of child care tasks amongst female consultants with dependant children under five years 225
8.7. Division of child care tasks amongst male consultants with dependant children under five years 225
8.8. Effect of family life on the career of consultant parents 230
8.9. Effect of family life on career of consultant parents according to speciality group 231
8.10. Effect of family life on career according to stage in career when first child was born 232
8.11. Effect of family life on career according to family type: consultant fathers 233
8.12. Effect of family life on career according to family type: consultant mothers 237
8.13. Current employment status of female consultants compared with employment status during training  
8.14. Current employment status of female consultants compared with employment status during training according to speciality group  
8.15. Mean age achieved consultant grade according to speciality group and employment status during medical training  
9.1. Reasons for final speciality choice amongst hospital consultants  
9.2. Reasons for final speciality choice amongst women consultants according to speciality group  
9.3. Family type according to speciality group  
9.4. Management of work and family roles amongst female consultants according to medical speciality group  
10.1. Typology describing the relationship between professional life and family life of hospital consultants  
10.2. Relationship between professional and family life according to medical speciality  
10.3. Attitude towards own work/family relationship  

Figures  
1.1. The hospital medical career structure (1948-April 1996)  
1.2. The revised hospital medical career structure  
1.3. Female medical students admitted to pre-clinical courses in the United Kingdom 1964-1994  
1.4. Percentage of female hospital medical staff by grade in England and Wales 1963-1995  
5.1. Work history of female consultants from the end of medical school to 1995  
5.2. Work history of male consultants from the end of medical school to 1995  
8.1. Employment status of female consultants from the end of medical school to 1995  
8.2. Employment status of male consultants from the end of medical school to 1995
INTRODUCTION

My interest in the inter-relationship between the professional life and the family life of doctors began in 1993, when I was working on a research project assessing the progress of South West Thames Regional Health Authority towards achieving goal three of Opportunity 2000. Opportunity 2000 was a scheme introduced by the government in 1991 which set eight goals, all of which aimed to increase the quantity and quality of women in the workforce (Opportunity 2000, 1991). One of these goals, goal three, was to increase the percentage of women consultants from 15.5 per cent in 1991 to 20 per cent in 1994 and to increase the number of women consultants in the surgical specialities from 9.7 per cent in 1991 to 15 per cent by 1994 (NHSME, 1992). Goal three was set in recognition of the under representation of women at consultant grade and in specific specialities in the medical profession.

By working on this project I became aware of the gender segregation that existed in the medical profession and also the high level of commitment and intensity of training required to be a hospital consultant (Dumelow and Griffiths, 1995), in particular, the intense training period of ten to fifteen years, the long working hours involving weekend and evening work and frequent geographical mobility during training. Careers in Hospital Medicine are also structured by clinical responsibility whereby consultants are the only grade to have full clinical responsibility. Limited periods of tenure are spent in each training grade, therefore the primary goal of a doctor embarking on a hospital career is achievement of a consultant post. A second aspect I became aware of was the low numbers of women who trained part time and the
negative attitudes in Medicine towards part time workers. These factors stimulated my interest in women who had become consultants, particularly, how they had managed their work and family roles. There is limited detailed information on how women consultants have managed their work and family roles, in particular how this varies for women in different medical specialities. The inter-relationship between professional life and family life of male consultants is also a neglected area of research.

My work on women doctors at South Thames Regional Health Authority (Dumelow and Griffiths, 1995) led to interest by the Regional Health Authority in the career paths of women who were working as NHS consultants in the Region. Funding was provided by South Thames Regional Health Authority to undertake this work and I developed this remit into a broader analysis of the inter-relationship between professional life and family life for both male and female consultants. The work for my thesis was undertaken as a collaborative PhD student while I was working as a Research Fellow in the Health Care Evaluation Unit at St. George’s Hospital Medical School.

My thesis addresses the inter-relationship between a professional career and family life in terms of how this relationship affects the employment careers of both male and female consultants. In particular, for women, how the inter-relationship between work and family is associated with horizontal segregation between specialities and vertical segregation within the consultant grade. Male consultants are included in the study to provide a comparison with women consultants and to facilitate better understanding
of the pattern of women consultants’ careers. The relationship between professional careers and family life has previously been studied for women’s careers in male dominated professions including Banking (Crompton, 1989; Savage, 1992), Engineering (Devine, 1992), Management (Wajcam, 1996a, 1996b) and Accountancy (Silverstone, 1980; Crompton and Sanderson, 1990a), but there has been little empirical research on women’s careers in Hospital Medicine. The remainder of this introductory chapter describes the outline of my thesis.

Chapter one provides a description of the medical profession in the United Kingdom, focusing particularly on Hospital Medicine. In this chapter, I begin by describing the working practices, career structure, and organisational culture in Hospital Medicine from the middle of the 19th century to the present day. The recent reorganization of specialist medical training and the considerable change in hospital doctors’ working practices over the past seven years are also discussed. The latter part of chapter one describes women’s entry into the medical profession at the end of the nineteenth century and the subsequent gender segregation which still persists today. I make comparisons with women doctors in other Western countries, to illustrate that gender segregation in the medical profession in the United Kingdom is similar to that in most industrialised countries.

I aim to demonstrate in chapter one that recent modifications to the career structure and working practices in Hospital Medicine have not been matched by a comparable change in attitudes and organisational culture. Hospital medical culture is still defined in terms of 'traditional' 'male' models of working and organisational discourses of time
which assume that the 'ideal' doctor has little or no involvement in their home or family life, and if married, has a partner providing full time domestic support. However, this culture does not fit with the changing nature of the medical workforce, where over half of the medical students are women who are likely to marry men in professional or managerial occupations and, analogous with this, there are increasing numbers of male doctors, who are in dual career or dual earner families.

Research literature on the careers of women in male dominated professions is discussed in chapter two. Examples of women’s careers in Law and Accountancy are used to illustrate that in most male dominated professions, women are under represented in the upper levels of the organisational hierarchy and the majority of women are working in different sectors of the profession to the majority of men. Explanations for gender segregation in male dominated professions which have been debated in the sociological literature are explored, in particular, whether gender segregation is associated with women’s orientation towards paid work or a reflection of organisational structures and patriarchy which direct women into particular areas within male dominated professions. In the final section of chapter two, I discuss the failure of equal opportunity employment policies to get to the root of gender inequality and recent arguments by feminist sociologists for a fundamental change in the structure of paid work which recognises that both women and men have families.

In chapter three I discuss the research literature on the family roles of professional women. In particular, the marriage and parenting patterns of professional women, the employment patterns of professional women after childbirth, unpaid work in the home
and the dual roles of professional worker and parent. These issues are discussed in the context of research literature on women doctors, and gaps in the research literature on the family roles of male and female hospital consultants are identified.

Chapter four provides a discussion of the methodology used in my thesis. In particular, it discusses why I chose to study Hospital Medicine in preference to General Practice or Public Health Medicine and why consultants were the only medical grade included in the study. It describes the sampling method used, the process of undertaking semi-structured interviews with 202 hospital consultants in one Health Region and the methods of analysis.

Chapter five provides an introduction to the analysis of the data on hospital consultants. It provides descriptive information about the professional life and family life of the sample of hospital consultants. Data on professional life are provided relating to the age that a consultant post was achieved, years in post, type of consultant post, distinction award holders and employment status of consultants. Data on family life are provided relating to marital status, occupation of partner and parental status of consultants, with particular details for teaching hospital consultants.

Analysis of the data on hospital consultants in chapters six to eight indicates that the relationship between professional life and family life is considerably different for male and female consultants. In chapter six, I discuss the effect that training to be a hospital consultant has on the personal life and family life of men and women. In particular, I examine gender differences in the effect that hospital medical training has on
developing personal relationships and on childbearing patterns. In the latter part of chapter six, the effect of a hospital medical career on family life as experienced by consultant parents is examined. In the final section of this chapter, I discuss the experiences of being a mother in a male dominated profession for women who became mothers either during training or at consultant grade. In particular, I highlight how male exclusionary practices constrained the choices of women doctors during the early months of motherhood and also discuss negative experiences of being a mother in a male dominated profession.

The relationship between family structure and the work/family relationship is explored in chapter seven. Despite working in the same profession and at the same grade, the domestic life of male and female consultants differs considerably. Five 'family types' are identified and used to show that the relationship between family structure and the work/family interface is different for men and women.

Chapter eight develops the analysis of the relationship between family structure and the work/family interface, by exploring the relationship between the paid work and the unpaid work of hospital consultants. Ways in which domestic labour has been organised to enable doctors to achieve consultant grade in Hospital Medicine, are discussed. The second part of this chapter examines how the relationship between paid work and unpaid work affects the medical career of men and women. In the last section of chapter eight the experiences of consultants who have followed non traditional career paths, i.e worked part time or taken a career break, are examined. In particular, I suggest that low uptake of part time training is influenced by male
exclusionary practices rather than personal choice. Gender differences in the speciality choices made by consultants are discussed in the first part of chapter nine. The latter part of this chapter explores how the relationship between professional life and family life is managed differently by women in different speciality groups.

Three types of work/family relationship which have been identified amongst male and female consultants are discussed in chapter ten. These are (i) the 'career dominant' work/family relationship, (ii) the 'accommodating' work/family relationship and (iii) the 'segregated' work/family relationship. The majority of male and female consultants have 'segregated' work/family relationships, although women were more likely than men to have a 'career dominant' or an 'accommodating' work/family relationship. Case studies of individual consultants are used to explore how different types of work/family relationship had a different outcome on family life and involvement in professional life for male and female consultants.

Finally chapter eleven provides a discussion of my conclusions, and an interpretation of my research data in the context of policy implications for the medical profession. The theoretical significance of my research findings for understanding women's employment in male dominated professions is explored. In particular, I discuss how the relationship between a medical career and family life was closely interlinked, particularly for women consultants and this relationship was important in influencing the pattern of women consultants' careers.
The professional life of a doctor in the United Kingdom has changed considerably over the last century. Prior to the 1940s, there were few formal career structures or organisational structures in the medical profession (Stacey, 1992). These informal structures changed with the advent of the National Health Service (NHS), which heralded the establishment of a formal career structure in Medicine (Stacey, 1992). The 1960s and 1970s saw an increase in the numbers of women training to be doctors (Elston, 1977), which reflected the increase in the number of women entering the labour market in the United Kingdom during this period. In the 1990s, the medical career structure and working practices in Hospital Medicine have undergone a further overhaul, with the introduction of the NHS reforms (Department of Health, 1989), a reduction in junior doctors' working hours (NHSME, 1991) and changes to the career structure for hospital doctors (Department of Health, 1993). The consultants in this study were training during the 1960s and 1970s and therefore the working practices and nature of the hospital medical workforce at that time was very different to the working practices of junior doctors currently in training.

Although women have been practising in Medicine since the last century, Hospital Medicine it is still a male dominated profession with a male organisational culture (Maddock and Parkin, 1993; Allen, 1994). This chapter provides an introduction to
the medical profession in the United Kingdom, focusing particularly on Hospital Medicine. It will discuss the organisational culture, training structures and medical workforce in Hospital Medicine in the context of the changes that have occurred over the past century. In particular, it will highlight the considerable change that has taken place during the professional life of consultants working in Hospital Medicine today.

1.2. The Structure of the Medical Profession in the United Kingdom

Prior to the middle of the nineteenth century, there were three groups of doctors, the qualified physicians, the barber-surgeons and the apothecaries (Stacey, 1992). There were also "woman healers" who undertook healing in the domestic domain, such as childbirth. The physicians, surgeons and apothecaries were not recognised as any type of collective identity until the 1858 Medical Reform Act when the General Medical Council was established (Stacey, 1992). This led to the development of a single medical register which was not only crucial for the establishment of Medicine as a profession (Stacey, 1992) but also led to the medical profession having a considerable amount of power, authority and autonomy (Hunter et al, 1994). By the 1930s, medical practice was divided into Hospital Medicine, General Practice and Public Health which heralded the beginnings of formal organisational structures within Medicine and also the continuation of a gendered pattern of work.

Nearly one hundred years after the 1858 Medical Reform Act, the National Health Service was established, creating the provision of health care as a public service and
also creating a bureaucratic organisation which became, and has remained, the employer of the majority of doctors in the United Kingdom. This bureaucratic organisation institutionalised a career structure (Ministry of Health, 1948) which remained virtually unchanged until the mid 1990s.

In 1993, there were 14,980 NHS appointed hospital consultants, 1620 honorary hospital consultants, 31,936 unrestricted General Practice principals and 366 consultants in Public Health Medicine working in the NHS (Department of Health, 1994). Doctors in Hospital Medicine, General Practice and Public Health Medicine specialise in different areas of medical practice. In Hospital Medicine, the majority of doctors train to be a consultant in a specialist area of medicine and work in NHS hospitals. There are two types of hospital; (i) district general hospitals, where doctors are primarily involved with service provision and (ii) teaching hospitals, where doctors are involved in service provision but are also involved in teaching medical students and research.

Both consultants and junior hospital doctors working in both types of hospital are employed on a contractual basis to work a set number of sessions per week. Consultants can either be employed full time, maximum part time or part time. Consultant posts are described in terms of sessions and a full time contract involves ten sessions per week, each session representing half a day (NHSME, 1995). Consultants who are employed on a maximum part time basis, work one session less than those who work full time and this session is normally spent in private practice work. As well as their sessional hours, consultants and junior hospital doctors
provide an "on call" commitment, whereby they provide twenty four hour cover for the patients under their care. Doctors of the same grade and in the same speciality take it in turn to be "on call". The amount of on call work varies according to medical speciality. In the acute specialities, on call work can involve providing cover every second night and every second weekend (1 in 2 rota). In the psychiatry specialities, on call commitment can involve providing cover every fourth night and every fourth weekend (1 in 4 rota).

Doctors in General Practice train to be principals in general medical practice and work in individual or group practice. Doctors in Public Health Medicine train to be consultants who specialise in the health of the population rather than the individual patient and primarily work in local purchasing health authorities. Doctors training in these three categories of medical practice can also work in academic medicine, where they can hold posts as Lecturer, Senior Lecturer, Reader or Professor and also retain honorary consultant contracts in the NHS. The British Medical Association (BMA) serves as a professional body and trade union for members of the medical profession and each medical speciality group is overseen by a Royal College. There are eight medical Royal Colleges (with associated faculties) in England and Wales. A Royal College is an independent body which is responsible for setting standards of training and accreditation of its members (NHSME, 1995).

Training to be a hospital consultant is the longest and perhaps the most arduous career path in the medical profession and the remainder of this chapter will focus on the hospital medical career. It will begin with a discussion of the training structure
within Hospital Medicine.

1.3. Training to be a Hospital Consultant

The medical career structure for hospital doctors in the United Kingdom is based on the principle that a junior doctor will spend a limited tenure in a number of training grades within a hospital based specialty which will lead eventually to a permanent post as a consultant, typically by the time the doctor is aged mid to late thirties. Training in Hospital Medicine is currently being restructured, which will create changes to the traditional career structure which has been in place for the past fifty years and, as I have discussed later in this section, doctors are likely to achieve consultant grade at a much earlier age than they have to date.

There have historically been two stages of medical training following graduation from medical school, general professional training (sometimes known as basic specialist training) and higher specialist training. General professional training is provided for all doctors whatever career path they plan to follow, either Hospital Medicine, General Practice or Public Health Medicine. General professional training involves one year as a pre-registration house officer, which is spent in a six month general medical post and a six month surgical post. This period is followed by three to four years at senior house officer grade (Figure 1.1). During general professional training doctors are required to be geographically mobile, since all posts are based on a contractual basis, and there are limited opportunities to train within one health Region.
Figure 1.1. The Hospital Medical Career Structure (1948-April 1996)
Before doctors can progress on to higher specialist training they are required to achieve membership of the Royal College of their chosen speciality. This is achieved by successfully completing the appropriate professional qualifications (MRCPsych, MRCOG, MRCP, FRCS).

Higher specialist training involves a period of two to three years spent in the registrar grade and a further period of three to four years in the senior registrar grade. Time spent training in these grades varies according to medical speciality. The acute specialities of general medicine, surgery and obstetrics and gynaecology generally involve a longer period of training than the other hospital specialities. A number of rotational training schemes are available in the higher specialist training grades, which enable hospital doctors to spend their training years at several hospitals within one geographical area (i.e. one Health Region) rather than in hospitals in different parts of the country. However, these rotational training schemes are not widely available and therefore the need to move to different areas of the country during higher specialist training is not uncommon.

After successfully completing higher specialist training and passing further professional qualifications, doctors are eligible to apply for a consultant post. In 1969, the following description of the consultant grade in Hospital Medicine was published:

"A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after
completing training in a speciality and, in future, being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post" (Department of Health and Social Security, 1969, p.6).

However, the consultant role is by no means homogenous. It varies according to speciality and according to the type of hospital the consultant is working in. In particular, the amount of time spent per week in the hospital varies according to the type of medical practice. A consultant surgeon is likely to spend a greater amount of time within the hospital when he/she is on call than a consultant psychiatrist, who is more likely to be able to provide on call cover over the telephone.

The current medical career structure is based on a full time continuous career model. However it does not reflect the demands of all doctors in training, in particular, the opportunity to change specialities, to train or work part time, to work abroad, or take a career break. The following section examines the opportunities to train or work part time in Hospital Medicine.

1.3.1. Part Time/Flexible Employment Opportunities

Part time employment opportunities are available during training and at consultant
grade. Part time training posts have been available since 1969, however part time consultant posts have only been available since 1991. During 1994 and 1995, funding for one hundred and seventy additional part time consultant posts was provided by the Department of Health (NHSME, 1995).

Part time training (more recently known as flexible training) in Hospital Medicine was first established in 1969 (DHSS, 1969). Initially, part time posts were made available for women doctors who were unable to work full time because of domestic commitments (Dowie, 1987). In 1979, part time training was modified and established under the PM(79)3 scheme (DHSS, 1979), which enabled doctors of both sexes who could not work full time for reasons relating to domestic commitments, illness or disability, to train part time. This scheme was primarily established for doctors in the senior registrar grade. Employing authorities were able to establish part time training posts for doctors in the registrar and senior house officer grades without central approval (Dowie, 1987). Applications for part time training at senior house officer level are managed by the postgraduate dean and are controlled by the Department of Health. Part time training opportunities were introduced in response to the increasing numbers of women entering the medical profession and the assumption that it would enable optimum use of the female workforce during the training years.

In 1993, the PM(79)3 was revised and is now known as Flexible Training: Senior Registrars (NHMSE, 1993). Under this scheme, appointment procedures for flexible training at registrar and senior registrar grade take place at a regional level and
applications to train part time are only considered once a year. There are three main stages towards obtaining a part time training post at registrar and senior registrar grade. These are; (i) manpower approval, (ii) educational approval and (iii) funding. Prospective part time trainees apply for a place on the scheme, and are interviewed by an appointments committee. Manpower approval is granted to successful applicants, after which applicants seek educational approval from the relevant higher training committee, followed by approval of funding from the appropriate NHS Executive Region (Morrell and Roberts, 1995). This lengthy process can be delayed further by suitable applicants being put on a waiting list because of limited training places being available.

In 1996, there were 626 senior registrars and 431 registrars training part time (Department of Health 1996, unpublished data). The central manpower committee sets quotas on a quarterly basis for the number of posts which are allowed in each speciality (Morrell and Roberts, 1995). In July 1994, two thirds of the available part time senior registrar posts in England and Wales were filled (461 out of 634 places). Only four places were taken by men (Morrell and Roberts, 1995). Part time posts are available in all specialities, although some specialities are more over subscribed than others. In some specialities, such as, anaesthetics, paediatrics and psychiatry, over a quarter of the women in higher specialist training are currently training part time (Goldberg, 1996), compared with the surgical specialities, where only a third of the available part time training posts were filled in 1994 (18 out of 58 places) (Morrell and Roberts, 1995).
A part time trainee’s contract involves five to seven sessions a week in comparison to a full time trainee’s contract which involves eleven sessions a week (Morrell and Roberts, 1995). One of the main advantages of the part time training scheme is the flexibility it provides to move to different geographical areas (Morrell and Roberts, 1995). However, despite being available for nearly thirty years, and advertised in the British Medical Journal annually, take up of the flexible training scheme is low. There also seems to be limited knowledge of the scheme amongst trainee doctors (Morrell and Roberts, 1995).

One of the problems regarding part time training opportunities in Hospital Medicine is the long delay from approval of funding to starting training, due to delay in allocating sufficient manpower quotas (Goldberg, 1996; Sayer, 1995). Other problems include minimal publicity of the scheme and negative attitudes amongst members of the profession towards part time trainees (Allen 1988, 1994). Attitudes towards part time training are still tainted with prejudice, with doctors who train part time being perceived as having less commitment to Medicine and are therefore less likely to be promoted (Allen, 1988, 1994; Goldberg and Goldberg, 1992). Part time training takes longer, therefore doctors who have trained part time may also face discrimination when applying for posts because they are older than their colleagues. However, findings from a national study of women consultants in 1995 showed that 33 per cent of women consultants had trained part time (Tait and Platt, 1995). Current restructuring of specialist medical training (Department of Health, 1993) may benefit part time trainees. In particular, it may simplify the process of obtaining part time training posts because advertisements will be placed for training programmes instead
of training posts (Morrell and Roberts, 1995). Part time work at consultant level is relatively new. The movement of women in and out of part time work at consultant level has not been studied in the past.

1.3.2. **The Doctor’s Retainer Scheme**

In 1972, a second scheme to encourage women doctors to remain within the medical workforce was introduced. This was called the Doctor’s Retainer Scheme (Department Of Health, 1972). Still available today, the Doctor’s Retainer Scheme offers a small amount of clinical work to women whose domestic commitments prevent them from taking on a regular professional commitment for several years (Department Of Health, 1972). To be eligible for the scheme, a doctor has to be able to work up to a maximum of one day per week and intend to increase his or her NHS work when domestic circumstances permit. Doctors on this scheme receive an annual retainer to meet expenses and they agree to maintain registration with the General Medical Council, to attend at least seven educational sessions a year, to register with a medical defence council and to subscribe to a medical journal (Dowie, 1987).

1.3.3. **Changes to the Hospital Medical Career Structure**

The current career structure is in the process of being revised following introduction of a new training structure outlined in *Hospital Doctors: Training for the Future: The Report of the Working Group on Specialist Medical Training* (Department of Health,
1993). Government policy aimed to introduce changes in postgraduate medical training to bring the United Kingdom in line with the European Union. The report introduced three main changes to postgraduate training; (i) to reduce the minimum length of postgraduate specialist training to seven years; (ii) to introduce a new Certificate of Completion of Specialist Training (CCST) and, (iii) to merge the registrar and senior registrar grades into one training grade. This will result in a more streamlined training programme (Figure 1.2) and provide greater opportunities for junior doctors to be based in one geographical area. The period of postgraduate training will be shorter, therefore, doctors will be able to achieve a consultant post at a much earlier age than at present. This will benefit women who choose to postpone childbearing until they have reached consultant grade. However it will also restrict movement between specialities, therefore doctors will need to have a clear idea of the speciality they wish to specialise in, at an earlier stage in their career. The new training programme will also restrict opportunity to gain clinical or research experience at home or abroad.

Unlike other professions, hospital doctors spend a substantial amount of time during the evenings and at weekends at work (i.e. in the hospital). Up until 1991, when new working hours for junior doctors were introduced, the average working week for junior doctors was one hundred and twenty hours, including a 1 in 2 on call rota system, which meant every second night and every second weekend was spent in the hospital, providing an on call service. With the change of government policy in 1991 to reduce the working week of junior doctors to 72 hours or less (NHSME, 1991), junior doctors are now required to spend less time in the hospital at weekends and
Figure 1.2. The Revised Hospital Medical Career Structure (from April 1996)

CONSULTANT

↑

SPECIALIST TRAINING (7 years)

↑

GENERAL CLINICAL TRAINING (1 year)

↑

MEDICAL STUDENT (5 years)
evenings. The reduction in the average hours on duty and the introduction of shift and
partial shift working should make it easier for women to remain within the profession
(Dillner, 1993). However, a 72 hour working week is still longer than the working
week in most professional occupations and still requires a substantial amount of
evening and weekend work.

1.3.4 The Changing Role of Hospital Consultants in the United Kingdom

The working lives of hospital consultants has changed significantly in the past fifteen
years. Changes occurring in the National Health Service since 1990 have had
considerable impact on the clinical practice and working life of hospital consultants.
Firstly, the reduction in junior doctors’ hours has led to an increase in consultant
workload, because the amount of assistance they receive from junior doctors has
decreased (Smith, 1995), which means that junior doctors have less continuous
responsibility for patients (Royal College of Physicians, 1996). With reduced
continuous support from junior doctors, patient care is increasingly becoming a
consultant provided service rather than a consultant led service. These changes will
be further reinforced by the implementation of the Calman proposals (Department of
Health, 1993) where there will be fewer junior doctors and consultants will have
greater direct responsibility for patients.

Secondly, the introduction of the purchaser/provider split in health care has led to
consultants having more involvement in management but also having reduced
autonomy, because managers have greater control over resources (Department of Health, 1989). Autonomy is one of the cornerstones of a profession and consequently this has reduced a consultant's ability to develop his or her own service, and has led to decreased morale and satisfaction amongst the consultant workforce (Ramirez et al, 1996).

Thirdly, changes in the NHS have led to increased involvement of consultants in non-clinical duties. In addition to clinical practice, hospital consultants are also involved in non-clinical duties such as management, training of junior doctors, involvement with Royal Colleges, teaching, audit and research. This increase in management roles has developed with little training being given to consultants on management skills. This approach whereby consultants have been expected to take on new and additional roles, with little support, has led to demoralisation and dissatisfaction amongst existing consultants (Smith, 1995). Opportunity to take study leave to learn new skills is limited because of the reduction in the number of junior doctors to support consultants (Ashley-Miller and Lehman, 1993).

Consultants are now more involved in training junior doctors. This has implications for the numbers of hospital consultants required to be in post to undertake these extra work commitments (Hunter and McLaren, 1993). However, the ratio of junior doctors to consultants has not changed significantly since 1948, despite recommendations from several government reports to increase the numbers of consultants in post (Ham, 1981; Joint Working Party on the Medical Staffing Structure in the Hospital Services, 1961; Royal Commission on Medical Education, 1968).
Fourthly, the introduction of The Patient's Charter (Department of Health, 1995), which identified a level of service which patients could expect to receive, has led to increased pressure on doctors to reduce waiting times and spend longer with their patients. Patients are becoming better informed and are demanding more care provided by consultants rather than junior doctors, as has traditionally occurred in the past. This rise in public expectation has also led to a rise in complaints from the public and consultants are increasingly dealing with cases of litigation.

The implications of these changes is that there is now a growing dissatisfaction and demoralisation amongst hospital consultants (Parker, 1990; Ramirez et al, 1996), increasing levels of stress and the loss of many qualified and experienced consultants to early retirement (Royal College of Physicians, 1996).

1.4. Organisational Culture and the Medical Profession

Despite changes to the working practices and career structure in Hospital Medicine, there are indications that a comparable change has not occurred in the organisational culture of Hospital Medicine. The culture and working practices within the medical profession are similar in many ways to other professions. However there are certain practices and traditions within Medicine which differentiate it from other professions, in particular, the long period of training, the need to spend an excessive number of working hours within the hospital, the requirement to be geographically mobile during the training years and a highly structured medical hierarchy.
Organisational culture can greatly influence the working life of prospective doctors through a process of socialisation, beginning at medical school and continuing throughout medical training (Merton et al, 1957; Miller, 1970; Bucher & Stelling, 1977; Light, 1980). Organisational culture is reinforced by a hierarchy at the top of the profession and sustained amongst trainee doctors, ensuring that professional values and attitudes are preserved. This culture educates and moulds prospective doctors in the knowledge, skills and values of the profession. However, it can also be influential in sustaining barriers and attitudes, to create a 'discouragement culture' (Maddock & Parkin, 1993, 1994) which can deter some doctors from pursuing a hospital medical career.

The organisational culture within Hospital Medicine can be defined as a 'male' occupational culture (Witz, 1992). Medicine has historically been a male dominated profession, which has led to working practices and career structures being organised around a masculine model of work. In Hospital Medicine, a culture exists whereby doctors are expected to give up everything for their career and provide one hundred per cent commitment to their work, which is necessary for their success on the career ladder. If a trainee doctor is to become a qualified autonomous hospital consultant there is little time available for personal or family life. The comments by Sir William Osler in 1894 published in The Student Life (Verney, 1957) reflect the organisational culture prevalent within Medicine during the nineteenth century;

"What about the wife and babies if you have them? Leave them! Heavy as are your responsibilities to those nearest and dearest, they are outweighed by
the responsibilities to yourself, to the profession and to the public. Your wife
will be glad to bear her share in the sacrifice you make" (Verney, 1957, p.9).

A century later this culture still exists in the medical profession today. However,
changes to the medical workforce in recent years, which I will discuss later in this
chapter, suggest that this culture is incompatible with the needs and demands of the
medical workforce in the 1990s.

1.4.1. The Hospital Medical Career Structure

The hospital medical career structure requires doctors to follow a linear career path
(Allen, 1988; Maddock & Parkin, 1994). Medicine is a very conservative profession
and diversity from this path is not always considered favourably and, as Allen (1988)
found in her study of doctors in the United Kingdom, the medical career structure is
advantageous to "conventional people with conventional careers" (Allen, 1988).
Inherent within this philosophy is the assumption that trainee doctors will achieve
different stages of their career at a particular age (Allen, 1988). Such assumptions
predominate either explicitly, through set age criteria for prospective senior registrar
trainees (Forster, 1993), or implicit assumptions made during the recruitment process.
Only two per cent of the medical school population are mature medical students
(Forster, 1993) which is considerably less than the proportion of mature students on
other university courses in the United Kingdom.

Career structures within organisations can also be influential in creating and
sustaining gender inequalities in the labour market, particularly within male dominated organisations (Crompton, 1986; Witz, 1992; Merritt, 1993). In historically male dominated professions, organisational structures have been defined by men which has created working practices and career structures which are geared to single men or women, or doctors with partners providing support at home who tend not to have careers themselves and are able to move frequently around the country.

Doctors who have trained part time, changed speciality more than once, or moved areas in line with their partner’s career may not fit this conventional model and therefore may be disadvantaged during the interview short listing process (Maddock and Parkin, 1993; Bynoe, 1992). The need to have a conventional career is increasingly affecting male doctors (Allen, 1994); with changes in women’s employment, more male doctors are likely to be married to, or cohabiting with, professional women. Allen (1988, 1994) found that some male doctors in training are facing constraints on their careers because they need to find jobs in the same area as their partners.

In this context, a medical culture which requires doctors in training to be geographically mobile, could have a substantial impact on the careers and family life of both male and female doctors. Previous work on women in organisations suggests that women perceive their limited choices and as a result, focus on personal rather than organisational reward (Savage, 1992). Therefore career structures and working practices may discourage many women from entering Hospital Medicine or when
working within it to specialise in an area which allows greater work flexibility and reduced competition.

1.4.2. **Working Hours**

Working hours in Medicine are based on a 'macho' culture (Maddock and Parkin, 1994) which suggests that a doctor is a better clinician if he or she works very long hours and attends breakfast meetings and late evening meetings. Hospital doctors are expected to provide one hundred per cent commitment to their patients plus take on additional responsibilities, such as audit, research and teaching. This leaves little time for personal or family life. Merritt’s (1993) comments on hospital culture reflect this point;

"The sanctity of life can be easily affirmed above profit seeking; but the value of a 100 hour week, involving meticulous attention to patients is more difficult to compare with a 45 hour work week that allows greater attention to the physician’s family" (Merritt, 1993, p.1607)

A 'macho' culture may discourage many women from entering Hospital Medicine and may be damaging to both men and women, in terms of their careers and their families. Within a culture where a full time continuous career model is considered to be the key to success, part time training is viewed as 'second class' and not a serious career option for committed doctors (Allen, 1994). It is not only women but men who are affected by the long working hours and the high level of on call
commitment required in Hospital Medicine, which has a detrimental effect on the personal relationships, marriage and family lives of junior doctors (Allen, 1994). The on call commitment and long hours were the most frequently cited constraint by both male and female doctors (Allen, 1988, 1994). An area of research that has been relatively neglected is the extent to which women doctors have worked full time when they would have preferred to have worked part time, how this varied by medical speciality and the effect this had on other aspects of women doctors’ lives.

Emphasis on a full time continuous career model, which is reinforced through a system of patriarchy in a male hierarchy, disadvantages doctors with families who have the main responsibility for child care, namely women. As Acker (1990) has argued, the organisational hierarchy within many organisations is gendered because those who are considered to be committed to paid employment are deemed more suited to positions of responsibility and authority, in comparison to those with additional commitments who predominate in lower positions within the organisation.

1.4.3 Equal Opportunities

With equal opportunities legislation and increasing numbers of female medical students it could be argued that the organisational culture within Medicine has changed. However, despite the increasing numbers of women in medical school, and in training, there are few women doctors in high status jobs in Medicine.

Subsequent to the 1975 Sex Discrimination Act and increased awareness of equal
opportunities, following the Opportunity 2000 scheme (NHSME, 1992), overt discrimination has decreased in the medical profession. However covert discrimination is still present, which is based upon sexist attitudes towards women doctors in general, and more specifically women doctors with families. Many doctors have stated that it is difficult to pinpoint this discrimination because it is covert and this is reflected in the 'glass ceiling' effect whereby women experience invisible barriers when trying to reach senior grades in the medical profession (Lorber, 1984).

Examples of the glass ceiling effect are evident in the progress of junior doctors up the career ladder. Women achieve higher grades at medical school and follow similar career success until the senior house officer stage of the medical career structure. After this stage, divisions occur and male junior doctors achieve greater success in working up the career ladder, whereas the progress of female doctors is typically slower (Hale and Hudson, 1992).

Unequal opportunities exist for men and women in Hospital Medicine. Allen (1988) found that women doctors face sexist attitudes, are seen as outsiders in the 'old boy network', and have few female role models or access to supportive networks. Despite equal opportunities legislation preventing interview panels from asking potential candidates about their intentions to have children, evidence of this practice within the medical profession still exists (Dumelow and Griffiths, 1995). Allen's study (1994) found that forty per cent of women compared to six per cent of men were asked during interviews about their intentions to have children.
1.4.4. Patronage

The British Medical Association describes patronage as "the encouragement given to an individual by a patron who favours, protects and gives influential support" (BMA, 1994). Patronage is an integral part of the hospital medical culture and there is evidence that it is increasing rather than decreasing (Allen, 1994). Under patronage, recruitment is based on sponsorship and the criteria for sponsorship is shared values and status (Johnson, 1979). Junior doctors are highly reliant upon references and support from senior colleagues during their training, which can determine the success or failure of their future careers. In a recent study of doctors, seventy per cent of young doctors thought patronage was important in furthering their careers (Allen, 1994).

Patronage has developed in a medical culture where no formal appraisal and careers guidance structures have existed. Within the male dominated profession of Hospital Medicine, the patronage system has created an 'old boys network', whereby job fixing and unsolicited references are rife (BMA, 1994). This very powerful system supports career advancement for some doctors but not for others (BMA, 1994). In a culture where there are few role models, women and overseas doctors are disadvantaged by the patronage system (Allen, 1994).

1.4.5. The Medical Hierarchy

A strong medical hierarchy exists within Hospital Medicine which is perpetuated by
the distinction between doctors in training, who are called 'juniors' and consultants who are referred to as 'seniors'. A junior doctor may be in his or her thirties and has spent ten years in training but will not be considered qualified to senior status until he or she has achieved consultant grade.

This type of hierarchy creates a competitive culture (Dillner, 1993). The numbers of trainees have outnumbered the number of available consultant posts in previous years (DHSS, 1987) which has created competition amongst junior doctors to achieve the best posts in the best hospitals. Government proposals in 1987 (DHSS, 1987) to reduce the level of competition and increase opportunities for doctors in training, by increasing the number of consultant posts and reducing the numbers of training posts, has not taken place (Audit Commission, 1995).

The hierarchical nature of Medicine is reinforced by the traditional working practice of 'clinical firms'. 'Clinical firms' were established prior to 1948 (Dowie, 1987), however in recent years a restructuring of traditional working practices has taken place, which have created changes to the 'clinical firm'. In the past, the hospital consultant would be head of a 'clinical firm', consisting of a consultant, one senior registrar or registrar, one senior house officer and one pre-registration house officer (Royal College of Physicians, 1996). As well as providing continuity of care, the aim of the 'clinical firm' was to provide an apprenticeship style of medical training (Audit Commission, 1995). This style of training reinforced the need for junior doctors to have support from senior colleagues who are recognised in their field. With changes to junior doctors' hours this historical 'clinical firm' has disappeared.
and shift and partial-shift systems have been introduced, which has reduced the opportunity for apprenticeship-style training. Hospital doctors now work in teams, where a small group of mixed grade junior doctors support two or three consultants in the same speciality (NHSME, 1995). Although these changes have reduced some of the hierarchial structures in Medicine, a strong medical hierarchy still predominates in Hospital Medicine today (Audit Commission, 1995).

1.5. Women in the Medical Workforce

Historically, the medical workforce consisted predominately of white, middle class anglo-saxon males. The medical workforce has changed dramatically over the last century with the increase of women and overseas trained doctors. These changes within the workforce have also been accompanied by gender inequality in the medical labour market. This section will illustrate how gender inequality has persisted throughout the 20th century, varying from overt inequality, in the form of recruitment processes and quotas to medical school, to covert inequality in the form of attainment of distinction awards and access to the upper levels of the medical hierarchy.

Women doctors were listed on the General Medical Council Registrar (GMC) for the first time in the late nineteenth century. In 1859, Elizabeth Blackwell was officially the first woman on the GMC register (Elston, 1986), although born in Bristol, she underwent her medical training in New York. In 1865, Elizabeth Garratt, later Elizabeth Garratt Anderson, was the first woman to obtain a medical qualification in the United Kingdom (Manton, 1964). The numbers of women doctors registered on
the GMC register increased from two in 1871 to one hundred by 1891 (General Medical Council, 1994).

During the late 1800s and early 1900s the patients of women doctors were primarily women and children. By the 1920s, the number of female medical students had greatly increased with the introduction of women only medical schools, the most notable in the South East of England was the London School of Medicine for Women (Elston, 1986). Gradually some medical schools became co-educational, however quota systems were in operation until 1975, where ten to twenty per cent of places were reserved for women entrants each academic year (Elston 1977, 1986). These quota systems were not wholly advantageous to women because they created barriers whereby only the best qualified women were given places at medical school (Elston 1977, 1980). Quota systems were finally removed under the 1975 Sex Discrimination Act, following which, there was a gradual rise in the number of female students admitted to medical schools in the United Kingdom (Figure 1.3).

1.5.1. Speciality Choice

There have been numerous studies undertaken on the early career preferences of doctors since the 1970s (Parkhouse, 1976, 1980, 1991; Parkhouse et al, 1983, 1981; Parkhouse and Ellin, 1988, 1990; Parkhouse and Palmer, 1979, 1977; Parkhouse and Parkhouse, 1989; Hutt et al, 1981; Lambert et al, 1996) which have shown that the career preferences and career paths of male and female doctors are considerably different. Many of the studies discussed in this chapter have also examined
speciality choice of male and female doctors, as part of a wider research remit on doctors’ careers (Allen, 1998, 1994).

Research on the career preferences of doctors has shown that General Practice has historically been a more popular area of medical practice for women than men. Recent surveys of medical school qualifiers show that in the past ten years there has been a slight decline in the proportion of women doctors showing preference for General Practice (52.5% in 1983 compared with 34.1% in 1993) (Lambert et al, 1996; Allen, 1988, 1994). Despite this decline, the proportion of women preferring General Practice amongst recent medical school qualifiers is still higher than men (Lambert et al, 1996).
The hospital medical speciality preferences of women and men on entry to medical school and at qualification also differ (Lambert et al, 1996). On entry to medical school, women are more likely than men to state paediatrics and obstetrics and gynaecology as their first preference and less likely than men to state surgery as their first preference (Lambert et al, 1996). However women are less likely than men to be working in their field of first preference seven years after qualification apart from those preferring general practice, radiology and psychiatry (Allen, 1988; Parkhouse 1991).

Different patterns in the career paths of women and men are also shown at consultant grade in Hospital Medicine. The percentage of women doctors varies between the medical specialities, ranging from 34 per cent of consultant paediatricians and 30 per cent of consultant psychiatrists to 4 per cent of consultant surgeons (Table 1.1). In the United Kingdom, training to be a surgeon or an obstetrician and gynaecologist requires approximately fifteen years of training which includes high levels of on call commitment, compared with a maximum of nine years training in psychiatry. Campaigns by the medical profession to encourage more women into the surgical specialities have been established, for example, the Women In Surgical Training Scheme (WIST) in 1991. It is still too early to know if these schemes are having any impact on the numbers of women surgeons achieving consultant grade. Reasons for speciality choice and change of speciality given by women doctors indicate that women are more likely to choose specialities which have greater compatibility with family commitments (Hutt et al, 1981; Parkhouse and Ellin, 1988; Rhodes, 1989; Tait and Platt, 1995).
Table 1.1. Percentage of female hospital consultants by speciality in NHS hospitals in England and Wales as at September 1995

<table>
<thead>
<tr>
<th>Speciality</th>
<th>England &amp; Wales Total Number of Consultants</th>
<th>England &amp; Wales % Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine Group</td>
<td>4430</td>
<td>14</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1169</td>
<td>34</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>311</td>
<td>13</td>
</tr>
<tr>
<td>Surgical Group</td>
<td>3963</td>
<td>4</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>1003</td>
<td>16</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>2655</td>
<td>23</td>
</tr>
<tr>
<td>Radiology Group</td>
<td>1477</td>
<td>24</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>265</td>
<td>22</td>
</tr>
<tr>
<td>Pathology Group</td>
<td>1799</td>
<td>28</td>
</tr>
<tr>
<td>Psychiatry Group</td>
<td>2382</td>
<td>30</td>
</tr>
</tbody>
</table>

(Source: Department of Health, 1996b)

1.6. Gender Inequality in the Medical Hierarchy

As well as under representation within particular specialities, women doctors are under represented in the senior grades of the medical profession. The proportion of women working in hospital grades decreases significantly as women progress up the career ladder (Figure 1.4). Women have historically been under represented in the career grades and in the upper levels of the hospital medical hierarchy. In 1995, only 19.4 per cent of NHS appointed hospital consultants were women (Figure 1.4) (Department of Health, 1996b). Under representation of women in career grades is also evident in academic medicine. Doctors working in academic medicine hold
honorary consultant posts in the NHS and in 1995 only 12.2 per cent of these posts were held by women (Department of Health, 1996b; Collier, 1996).

Women are over represented in the sub consultant grades in Hospital Medicine. The main career grade in Hospital Medicine is the consultant grade which has been discussed earlier in this chapter. There are two other career grades which are the associate specialist grade and the staff grade. Both grades are permanent and involve a lower level of clinical responsibility than that of consultant (Department of Health, 1988).

The staff grade was introduced in 1988 to encourage women to pursue a hospital career (Department of Health, 1988). The staff grade is available to doctors who are unwilling or unable to become a consultant, but who wish to remain in Hospital Medicine (BMA, 1990). There were 1,110 staff grade doctors in England in 1993 (Department of Health, 1994). The majority of the doctors in these posts were either women or overseas doctors. However, the introduction of the staff grade post has not been advantageous to women doctors. While there is demand amongst women doctors for career grade posts without the full range of consultant responsibilities (Allen, 1994), the staff grade post is viewed by many doctors as a second class, dead end job which was not an option for the career minded doctor (Allen, 1994; Panday, 1994).
A survey of staff grade doctors in 1991 (SCOPME, 1994) showed that twenty nine per cent of staff grade doctors had entered the grade from registrar grade rather than from senior house officer grade as predicted. Domestic commitments and dissatisfaction of continuous on call responsibilities were important factors given by women working in the staff grade post (SCOPME, 1994). The staff grade was supposed to provide an intermediate level of clinical responsibility with the opportunity for continuous training, however, in practice, staff grade doctors take on high levels of responsibility, on-call work, and have little opportunity for study leave (Panday, 1994). Therefore, women doctors who have been unable to achieve consultant grade, have been diverted into a grade which provides little of the rewards
available in the consultant grade.

The associate specialist grade was introduced in 1981 and it is a personal appointment which is available to doctors who have not been able to achieve consultant grade for personal reasons (Dowie, 1987). There has been an increase in the numbers of associate specialist posts in the past five years. Figures for 1996 show there were 1,100 associate specialist posts in England and Wales, compared with 908, four years previously (Macdonald et al, 1996). Similar to staff grade doctors, research suggests that associate specialist doctors have onerous on call rotas, no study leave and no educational advice (Mcdonald et al, 1996). Similar to the staff grade, the majority of associate specialist doctors are women and many have not completed their postgraduate qualifications. Lack of qualifications and training may prevent associate specialist doctors from being awarded the new Certificate of Completion of Specialist Training (CCST) (Department of Health, 1993) which could lead to further isolation of non consultant career grades in Hospital Medicine (Macdonald et al, 1996).

Women doctors are also under represented in the upper levels of the medical hierarchy. The number of women doctors on national committees, or representatives at the Royal Colleges is low. To date, there has only been one female president of the Royal Colleges, the Royal College of Psychiatrists. Previous research has highlighted the lower number of women doctors at consultant grade (Allen, 1988, 1994). Consultant’s careers and reasons for women’s low involvement in the upper levels of the medical hierarchy is a relatively neglected area of research.
The proportion of women consultants (20%) achieving distinction awards is also lower than male consultants (37%) (Gough, 1994). Distinction awards are monetary awards which are given to consultants in recognition of their outstanding work and contribution to medical practice. By retirement, approximately sixty per cent of consultants will hold an award (Department of Health, 1990). Distinction awards range from A plus to C, with an A plus award doubling the consultant’s salary. However these awards are less frequently given to doctors in specialities such as psychiatry, geriatrics and anaesthetics, where there are a higher proportion of women.

Figures for 1993 reveal that of the 6,058 awards granted in this year, 90.5% were given to men and only 9.5% were given to women (Chadda, 1994). Reasons for these figures may be the younger representation of women in the medical profession, since most awards are given to older doctors (Chadda 1994).

There has been much criticism of the selection criteria for distinction awards, both inside and outside the profession (Gough, 1994; Chadda, 1994). Criticism has been directed at the secrecy and lack of clear criteria for allocating distinction awards. There is limited information available because they are granted by doctors to doctors. It may be the case that women are not being put forward for these awards because they have not matched the criteria to receive an award. However what needs to be questioned is whether there are women who have made considerable contribution to their medical practice but are still failing to obtain an award. In September 1992, an independent review of the merit award system undertaken by York University concluded that;
"a rationale for these payments is absent and that there is little relationship in the value of awards and the available crude indicators of productivity or excellence" (Gough, 1994, p.17)

1.7. Women in the Medical Workforce in other Western Countries

It could be argued that once the fifty per cent of female medical students progress through the career ladder the current gender inequality will disappear. However, gender inequality also exists in the medical profession in other countries, such as the United States of America, Canada, Finland, the Czech Republic and the former Soviet Union (Bowman and Gross, 1986; Williams et al, 1990; Riska, 1988; Riska and Wegar, 1993; Crompton, 1997a).

In Finland and the former Soviet Union, which have historically had high numbers of female doctors in training over the past century, women doctors are still under represented in the senior grades of the profession and they predominate in specific specialities. Historically, there has been a high percentage of women doctors in the former Soviet Union. Since as early as 1928, women comprised forty five per cent of the entrants to medical school (Dodge, 1966). However, gender inequality exists and is reflected in the low numbers of women doctors in the top positions of authority or power (Dodge, 1966).

Finland was the first Nordic country to allow women to enter medical school in the late 1800s (Riska and Wegar, 1993). However, in 1983, only twelve per cent of the
chief ward doctors and fourteen per cent of chief doctors at hospitals were women, compared to forty four per cent of doctors and forty per cent of assistant doctors at municipal health centres (Finnish Medical Association, 1991). Specialists who work in hospitals are more involved in teaching, research and administration of health care, consequently female doctors in Finland are under represented in positions of power or authority (Riska and Wegar, 1993).

In countries where women entered medical school at a similar time to the United Kingdom, such as the United States of America, Canada and the Czech Republic, a similar pattern of gender segregation exists. In the Czech Republic, only 14 per cent of women were surgeons in 1994, compared with 77 per cent of women who were paediatricians (Crompton, 1997a). Female doctors in many western countries are over represented in the same specialities. Table 1.2 shows the percentage of women doctors working in selected specialities in the United States of America, Finland and the United Kingdom. Although these data are over ten years old, they provide a comparison across the three countries. More recent data show that the proportion of women doctors across the specialities in these countries has not changed (Clark, 1991; Riska and Wegar, 1993; Allen, 1994), and shows that women doctors in these three countries still practice in similar areas. However, a higher proportion of women practice in obstetrics and gynaecology in Finland and the United States of America than in the United Kingdom. One reason for the difference in obstetrics and gynaecology in the United Kingdom could be that training structures, length of training and working patterns of obstetrics and gynaecology specialists are similar to surgery, which is not the case in other countries.
Table 1.2. Percentage of female doctors in selected hospital medical specialities in the U.S.A., Finland and the United Kingdom

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Female</td>
<td>% Female</td>
<td>% Female</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>35</td>
<td>56</td>
<td>17</td>
</tr>
<tr>
<td>Pathology</td>
<td>21</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>20</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>18</td>
<td>29</td>
<td>11</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>17</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>Surgery</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Source:
Finland: Finnish Medical Association 1988

1.8. Summary

Consultants working in Hospital Medicine today have undergone significant changes to their daily working life. Consultants who trained twenty years ago were training in an environment where there were fewer women doctors, a working week of one hundred and twenty hours was not uncommon, and where Medicine was a consultant led service and consultants had autonomy over patient care. These consultants are now working in an organisation where junior doctors in training have fewer working hours, more of the junior doctors are women, and Medicine is becoming a consultant provided service with reduced autonomy over patient care. The working life of
hospital doctors has changed significantly, so that consultants in Hospital Medicine
today have needed to adapt to a way of working which they had no conception of
when they were training.

While changes have taken place in the career structure and working practices, the
organisational culture of Hospital Medicine has essentially remained the same.
Despite, pressure to create more formal career guidance and more formal procedures
of assessment (Allen, 1988), a system of patronage is deeply ingrained within hospital
medical culture. Attitudes towards more flexible working practices are still tainted
with prejudice and the philosophy still prevails that a doctor is only committed to
his/her career if he/she has little personal time.

Gender inequality in the medical profession is still prevalent. Although it is masked
by equal opportunities policies, there is a long way to go before equality between
male and female hospital doctors exists. As a woman manager is reported to have said
at an Opportunity 2000 conference in 1993 (Dillner, 1993), only when there are as
many mediocre women at consultant level as there are mediocre men will equality
exist.
CHAPTER 2

Women's Careers in Male Dominated Professions

2.1. Introduction

The entry of women into male dominated professions has been a popular area of academic debate in the sociological literature (Epstein, 1970, 1981; Silverstone and Ward, 1980; Spencer and Podmore, 1987; Crompton and Sanderson, 1986, 1990a; Bottero, 1992; Devine, 1992; Riska and Wegar, 1993; Wajcman, 1996a, 1996b). In this chapter I will examine research literature on women's careers in male dominated professions, in the context of traditional career models, male orientated working practices and gender segregation.

In the first part of this chapter, I will discuss two issues; (i) how women's entry into the medical profession (see chapter one) is similar to women's entry into other male dominated professions, such as, Law and Accountancy and (ii) the gendered nature of a career in male dominated professions. The final part of this chapter will discuss recent arguments by feminist sociologists (Rubin, 1997; Liff and Cameron, 1997; Lewis, 1997) which propose new directions in equal opportunities policies and are particularly relevant for male dominated professions.

Firstly, a brief explanation of male dominated professions is needed. Historically a division between female dominated professions (i.e. nursing, primary school teaching) and male dominated professions (architecture, engineering) has existed. The female dominated professions are also known as semi-professions. However, a process of
feminisation is occurring in a number of the male dominated professions, such as, Medicine, Law, Accountancy and Banking (Silverstone and Ward, 1980; Spencer and Podmore, 1987; Crompton, 1989, 1995; Crompton and Sanderson, 1990, 1994; Savage, 1992), which are referred to in this chapter as traditionally male dominated professions.

2.2. The Concept of a Career

Professional workers are typically associated with having a 'career', rather than a 'job'. A career conventionally involves acquisition of qualifications and progression through a career ladder involving various stages of seniority. The professions developed at a time when the majority of professionals were men and therefore it has been argued that professional occupations are embodied in "a masculine vision of professional work" (Davies, 1996, p.661). This has created careers which are conventionally linear and hierarchical. In particular, career is a gendered concept (Dex, 1985; Beechey, 1987; Evetts, 1994). Halford et al (1997) argue that conventional careers are "based on male work life patterns but presented as a gender neutral concept, whilst in practice the accomplishment of this type of career has been more open to men than women." (Halford et al, 1997, p.109). Career models were established which assumed that careers would follow specific paths, would be full time, continuous and progress upward through stages of an organisational hierarchy (Hearn, 1977). This type of career model is particularly prominent amongst professions which have traditionally been male dominated, i.e. Medicine and Law
However, the linear career model does not reflect the careers of the majority of women whose employment careers are closely inter-connected to their domestic careers (Dex, 1984). In other words, child care and family responsibilities will be the responsibility of many women during their employment career which may lead them to postpone taking on new responsibilities or delay career goals (Evetts, 1994).

Applying a traditional career model to the working lives of women is disadvantageous to women (Pascall, 1994) because it leads to the suggestion that women’s careers, which may not follow a linear career model, are deviant (Dex, 1985; Beechey, 1987; Itzin and Newman, 1995). Different types of career have been identified by Crompton and Sanderson (1990a). They differentiate between ‘organisational’ careers, where employees pursue a career within one organisation and typically involve a linear career path, compared with ‘occupational’ or ‘practitioner’ careers, where employees move from employer to employer and typically work part time and/or take career breaks (Crompton and Sanderson, 1990a). The former is considered to be a masculine career path, the latter a feminine career path. Hence gendered career paths exist which Halford et al, (1997) argue are generated by organisational processes and dominant groups within organisations. In their research on careers in Banking, Nursing and Local Government, Halford et al, (1997) identify different types of career strategies. They differentiate between ‘contingent’ careers, whereby men and women change their career path according to emerging opportunities and ‘strategic’ careers, whereby career development is pre-planned.
Strategic careers were more evident in the female orientated profession of Nursing but lacking in the male dominated professions of Banking and Local Government.

Traditional models of career are being questioned (Marshall, 1989; Evetts, 1994; Itzin and Newman, 1995; Halford et al, 1997). There is evidence in some professions, such as, Banking, Nursing and Local Government that traditional career routes are changing and increasingly being streamlined and less hierarchical as a result of restructuring within these professions (Halford et al, 1997). Support for the concept of career to be de-gendered has been raised by Evetts (1994), so that men's and women's careers are understood as a different concept without any assumption that certain types of career are deficient. Marshall (1989) argues for a move away from focusing on the linear career towards recognising career as involving cyclic phases which capture the ebb and flows in career progress. The careers of successful professional women and men tend to be uni-dimensional. They have been required to act as if they have no family life (Kanter, 1977) and this is certainly true in the medical profession, where doctors who have pursued a hospital career are expected to have little, if any, family life (see chapter one).

Evetts (1994) argues that focusing on a uni-dimensional career places the conceptualisation of a career exclusively in the context of paid employment and does not allow for the incorporation of personal and family responsibilities in career construction, other than as a hindrance to a successful career. Employment careers are closely interlinked to other aspects of life (i.e family life and unpaid work in the home) (Johnson, 1985; Halford et al, 1997; Crompton, 1997b). This is particularly
evident for women and this relationship is an important influence in the structuring of women’s employment (Crompton, 1997b). Halford et al (1997) found in their research on the careers of men and women in Nursing, Banking and Local Government, that women talked about their work histories and careers in the context of managing their home/work responsibilities, compared with men who rarely referred to their lives outside their work when talking about their careers.

This has led some sociologists to argue for a reconceptualisation of a ‘successful’ career away from a uni-dimensional career with a linear career model and minimal involvement in personal life towards a multi-dimensional career which encompasses an appropriate balance between professional work, daily and personal life (Evetts, 1994; Itzin and Newman, 1995).

### 2.3. Working Patterns in Male Dominated Professions

Women’s entry into employment in the United Kingdom has been characterised by their involvement in part time work (Martin and Roberts, 1984; Hakim, 1993b; Brannen et al, 1994). Half of the employed women in the United Kingdom work part time (CSO, 1996). However, women’s working patterns in male dominated professions are characterised by full time continuous work, with little opportunities for flexible or part time working. In addition, the majority of male dominated professions operate in an organisational context in the United Kingdom, which generally imposes working hours incompatible with family life and which perpetuates gender exclusion (Crompton, 1987). In combination with this, the ‘ideal’ professional
is associated with someone whose work dominates all aspects of their life and anything different is considered to be less than full commitment to their professional work (Epstein, 1970).

Women who want to achieve high status within the occupational structure are therefore constrained to follow 'masculine' career paths. However, these working practices have been established and depended upon the assumption that workers have full time domestic support and are available to work all hours available (Kanter, 1977; Finch, 1983; Crompton and Sanderson, 1986). Consequently women's entry into the professions has been characterised by following 'masculine' models of work or being marginalised into sectors of their profession by following 'feminine' models of work, characterised by part time work and career breaks. In general, part time work has been associated with downward occupational mobility (Beechey and Perkins, 1987) and has been given marginal status as a 'peripheral' form of employment (Dey, 1989, p.475).

Part time work is less common amongst women in professional occupations than amongst other occupational groups (Dale and Glover, 1990). In the higher occupational groups, (i.e. professionals and managers), only six per cent of women work part time (Dale and Glover, 1990). In addition, opportunities for part time work in professional occupations predominate in less prestigious sectors or 'occupational niches' (Crompton and Sanderson, 1990a). In Accountancy, part time working opportunities are limited in organisational careers but available in practitioner careers. In Medicine, the opportunities for part time work are minimal in Hospital
Medicine, apart from sub consultant grades such as the staff grade (Elston, 1993), but available in General Practice and Community Medicine. In Hospital Medicine, part time working is available in shortage specialities such as, psychiatry but limited in oversubscribed specialities such as surgery (see chapter one) (Elston, 1993).

Studies of women doctors who have achieved consultant grade and worked part time during their career are limited, because the majority of studies of doctors in the United Kingdom focus on doctors in training, apart from the few studies which focus particularly on the career paths of part time trainees (Goldberg and Goldberg, 1992). Tait and Platt's (1995) work is the most recent study of consultants which shows that 33 per cent of women consultants had worked part time at some point in their career.

Although opportunities for part time working have increased in recent years, as a consequence of equal opportunity campaigns, they have been accompanied by negative attitudes towards part time workers. These negative attitudes exist because organisational discourses of time are constructed whereby less than full time work is associated with lower commitment to paid work (Lewis, 1997). Other feminist sociologists have stressed the need to challenge traditional models of work (Rubin, 1997; Liff and Cameron, 1997) and to create models of working which incorporate non work commitments for both men and women, rather than the perpetuation of working practices which "interfere with family life and help maintain gender inequalities" (Lewis, 1997, p.21).

Length of working hours and training have been shown to be an important factor in
preventing women from achieving senior status in the medical profession (Allen, 1988). These working patterns may lead many women doctors to leave Hospital Medicine, and many women who have achieved consultant grade in Hospital Medicine may have worked full time during their career when they would rather have worked part time. How working full time affected the family life of women doctors is an important but relatively neglected area of research.

2.4. Women in Male Dominated Professions

Women first entered the professions in the late 1890s and early 1900s, however, they were not represented in any substantial number. In the last two decades the proportion of women entering traditionally male dominated professions has increased dramatically (Crompton and Sanderson, 1990a). Women now constitute a significant proportion of new entrants to professional jobs (Crompton, 1995; Fielding, 1995). This increase was largely the consequence of women gaining the required qualifications to enter the professions, or what Crompton and Sanderson (1986) have described as 'pulling the qualifications lever'. Women in professional occupations have access to greater resources to manage their work and family life, than women in other occupations, however their experiences in the labour market are not considerably different from women in other types of employment.

The marginalisation of women in the labour market has been documented extensively, however in the 1980s, feminist sociologists highlighted evidence of a similar
marginalisation occurring in professional occupations. In chapter one I discussed the segregation of women doctors within particular specialities in Hospital Medicine and their under representation in the upper levels of the medical hierarchy. Gender segregation in other traditionally male dominated professions, such as, Law and Accountancy also exists.

There has been an increase since the 1970s in the number of women practising in the legal profession, with currently over 40 per cent of qualifiers from Law school being women (Hakim, 1992). In 1991, 42 per cent of those called to the Bar were women compared with 7 per cent in 1972 (Hakim, 1992; Evetts, 1994). However, among the senior positions of the legal profession, women are under represented as QCs and at the judicial level (Wallach, 1992). Only 8 to 9 per cent of members of professional institutes in Law are women (Hantrais and Walters, 1994).

Women are also marginalised within particular sectors of the legal profession. Women lawyers predominate amongst family law rather than criminal and advocacy work, where men predominate (Spencer and Podmore, 1987). Women lawyers are also over represented in particular types of job, such as research, writing briefs and providing legal assistance, and are less likely than male lawyers to be in the public, corporate and litigation specialities (Epstein, 1981).

The numbers of women practising as solicitors has rapidly increased from 15 per cent in 1986 to 23 per cent in 1990 (Evetts, 1994). However, at senior level, only 12 per cent of partners are women (Shuaib, 1991) and male solicitors achieve partnership at
twice the rate of women (Hansard Society, 1990). Women solicitors are more involved in matrimonial work, wills and probate compared with male solicitors who are far more likely to be involved in criminal and litigation cases (Podmore and Spencer, 1987).

Entry of women into Accountancy is proportionally lower than Law or Medicine (Boyer, 1995). In 1995, 14 per cent of the accountancy profession were female (Trapp, 1995). The proportion of female students in Accountancy compared to female students in other professions is also lower (36 per cent in Accountancy compared with 52 per cent in Medicine) (Boyer, 1995). Women are also underrepresented in senior posts within Accountancy, 28 per cent of men in accountancy firms were partners by the age of 36, compared with only 14 per cent of women (Grosvenor, 1989). Few women are represented on the management or executive committees of the accountancy bodies (Boyer, 1995). There are two main areas of practice in Accountancy: organisational careers in industry, commerce and finance, or 'practitioner' careers. A greater proportion of women than men pursue organisational careers. Women accountants are more likely to be employees in accountancy firms (76%), compared with men who are more likely to be self employed and set up in solo practice (Hantrais and Walters, 1994).

There has been a rapid increase in the number of women admitted to the Institute of Chartered Accountancy in England and Wales (ICAEW) since the 1970s (Crompton and Sanderson, 1990a). However, 50 per cent of men were partners compared with only 7 per cent of women were partners in 1995 (Boyer, 1995). Chartered
Accountancy in the United Kingdom is mainly structured around large organisations. Women are much less likely to achieve partnership in a large firm than men. Twenty-three per cent of women were partners in a large firm compared with 64 per cent of men. In comparison, roughly equal numbers of men and women were partners in small firms (24 per cent and 22 per cent respectively) (Boyer, 1995).

The majority of women in male dominated professions work in particular areas of practice which differ from the majority of men and few women predominate in the popular, high status sectors of male dominated professions, or the upper levels of the organisational hierarchy (Epstein, 1970; Savage, 1992). In particular, women’s entry into male dominated professions has been accompanied by a growth of women ‘practitioners’ who predominate in less prestigious sectors or ‘occupational niches’ in their profession (Crompton and Sanderson, 1990a; Savage, 1992; Crompton, 1995). Importantly, these occupational ‘niches’ restrict women from reaching their full potential because they entail using specialist skills and expertise but they are not positions of power or authority (Crompton and Sanderson, 1990a).

2.5. Gender Segregation in Male Dominated Professions

Gender segregation in employment, both in the professions and the labour market in general, can be considered in terms of horizontal and vertical segregation (Hakim, 1979). Horizontal segregation can be used to describe the clustering of women into particular areas of practice within the same occupation, for example, in Law,
Medicine and Accountancy, the majority of women are working in different areas to the majority of men.

The entry of women into previously male dominated professions has led to a change in the level of vertical occupational segregation (Hakim, 1992). Vertical segregation is a term used by Hakim (1979) to explain the different positions of men and women in the occupational structure. The entry of women into male dominated professions has been paralleled by a discussion of whether the entry of women into new areas in the occupational structure has led to a reduction in gender segregation (Crompton, 1989; Crompton and Sanderson, 1990a; Devine, 1992; Bottero, 1992). At first, women's entry into male dominated professions was viewed as representing a reduction in direct and indirect forms of exclusion (Crompton and Sanderson, 1986), although later it was recognised that women were increasingly facing barriers to promotion because of linear career models and male occupational cultures (Reskin and Roos, 1990; Walby, 1991) and women were under represented in senior posts in the upper hierarchies of their profession.

The existence of gender segregation in male dominated professions has been described as representing 'continuity in change' (Crompton, 1989), whereby change has occurred in women's position in the occupational structure but gender segregation has continued by the marginalisation of women into particular sectors of male dominated professions (Crompton, 1989; Walby, 1991). Crompton (1997b) has argued that women's entry into male dominated professions has created a re-segregation, whereby women in male dominated professions are over represented in some areas and under
represented in others. For example, in Hospital Medicine, more women than men are working in staff grade and associate specialist posts and there are fewer women at consultant grade, particularly in London teaching hospitals. Few women consultants hold senior positions on national committees or the Royal Colleges and are less likely than male consultants to receive a distinction award (see chapter one).

Explanations for the pattern of women’s employment have been centred around two major debates; gender segregation is a reflection of women’s individual choices and preferences towards paid work which are set in the context of their domestic responsibilities (Hakim, 1991, 1995) or alternatively gender segregation is the consequence of male exclusionary practices and organisational practices and structures which direct women into particular areas of the labour market (Hartmann, 1976; Walby, 1990). Between these two extremes is an argument which proposes that the pattern of women’s employment can be explained in terms of both individual choices and structural constraints (Crompton and Sanderson, 1990a; Ginn et al, 1996; Bruegel, 1996b; Crompton, 1997b). The following section will discuss these debates.

2.5.1. Individual Choice and Personal Preference

One argument to explain the pattern of women’s employment in the United Kingdom has been the individual orientation of women towards paid work (Hakim, 1991, 1995, 1996). Essentially, Hakim argues that the structure of women’s employment is the result of individual choices made by women. Hakim (1991) suggests there are two
types of women in the workforce, one group which has work commitment similar to men, leading to a continuous full time career. The second group "has little or no commitment to paid work " (Hakim, 1991, p.113) and gives priority to their domestic life, leading to part time work. She suggests that women with low commitment to paid work fail to invest in their human capital (i.e. educational and professional qualifications) to gain access to higher levels of the occupational structure.

Hakim’s suggestion (1995) that part time workers and full time workers have different commitment to work has been strongly contested by other feminist sociologists (Ginn et al, 1996; Bruegel, 1996b) arguing that family situations are likely to reflect the employment situations of women and does not equate with lower commitment to employment. In particular, Hakim fails to take into account the constraints in which decisions about paid work are made, within the family and within the organisational structure.

Before I discuss the influence of structural constraints on women’s careers, I will briefly discuss a second axis of the 'choice' debate which suggests that women predominate in particular areas of employment because they have a natural aptitude to particular types of work. This work involves caring, nurturing and communication, which are perceived to be a natural extension of women’s domestic work. Within traditionally male dominated professions, women predominate in particular areas of practice which could be associated with caring and communication roles, for example, family law in the legal profession and psychiatry and geriatrics.
While natural aptitude to a particular type of work may be one of the factors influencing gender segregation, it does require further discussion. This theory raises the question, are women attracted to this type of work because they are biologically better at it, or have women learnt through gender socialisation which type of work they assume they are best suited to perform?

Research suggests that gender socialisation is a major influence on the career paths of female doctors (Martin et al, 1988). Martin et al (1988) suggest that women may be attracted to primary care specialities in Medicine because they emphasise nurturing, empathy and communication and, as a consequence of gender socialisation, it may seem more natural for women to work in these areas. Under representation of women in senior posts in Medicine may also reflect the fact that women have not been socialised into thinking they should strive for these positions (Martin et al, 1988, p.336).

2.5.2. Structural Constraints

An alternative argument to explain the pattern of women’s employment in the United Kingdom has been the structural constraints within organisations which have directed women into a particular sector of the labour market (Walby, 1990; Reskin and Roos, 1990; Acker, 1990; Cockburn, 1991; Savage and Witz, 1992; Itzin and Newman, 1995). Factors which have been considered influential in perpetuating gender
segregation are gendered organisational cultures, employer’s attitudes, male orientated working practices and exclusionary practices maintained by the occupational monopoly of one dominant group (i.e. men).

One key argument dominating the sociological literature on gender relations in employment is the gendered nature of organisational culture (Cockburn, 1988; Acker, 1990; Savage and Witz, 1992). This argument is particularly relevant to explaining gender segregation in male dominated professions where organisational structures have been defined by men. In particular, the ‘male’ culture within organisations sustains and perpetuates gender segregation (Hearn and Parkin, 1987; Acker, 1990; Cockburn, 1991; Savage and Witz, 1992).

Evidence of gendered organisational cultures have been discussed in empirical research in professional and managerial occupations (Spencer and Podmore, 1987; Silverstone and Ward, 1980; Wajcman, 1996b; Davidson and Cooper, 1992; Crompton and Sanderson, 1990a). Cultures within organisations when discussed in the context of gender are usually referred to as a ‘root metaphor’ (Smirich, 1983). Culture as a ‘root metaphor’ describes something an organisation ‘is’ (Smirich, 1983) and refers to the deeply embedded values and assumptions which are shared by individuals in organisations (Mills, 1988).

These values and assumptions are transmuted to individuals during the early stages of professional life, for example, as I have discussed in chapter one, medical students learn early the accepted ways of behaviour. These values and assumptions are
gendered because they are based on the roles women and men are thought to be best suited to perform in organisations (Beechey and Perkins, 1987; Abbott and Wallace, 1990), working practices which have been defined by 'male' definitions of work, the greater value placed on employees who do not allow family commitments to intrude into their working lives (Lewis, 1997) and recruitment of people who reflect the norms and values of an organisation (Kanter, 1977; Webb and Liff, 1988; Mills and Tancred, 1992).

Beliefs about gender appropriate jobs have been documented in the literature as one aspect underpinning gendered organisational culture (Cockburn, 1988). Assumptions about the types of work men and women are best suited to perform can lead to discrimination in gaining access to an occupation and difficulty in being promoted once within it (Beechey and Perkins, 1987; Abbott and Wallace, 1990). Kanter (1977) found, in her study of managers in a large corporation, that employers held views about the kind of people that should occupy senior and junior organisational positions. Spencer and Podmore (1987) argue that the legal profession is characterised by its aggressive and masculine nature, and show that assumptions were held by male members of the profession about suitable aspects of legal work for women. Criminal and advocacy work require competitive, aggressive and extrovert qualities compared with matrimonial work where sympathy and tact were required. Assumptions held by male members of the profession were that the former was more suitable work for men and the latter more suitable work for women (Spencer and Podmore, 1987). Assumptions concerning the appropriate roles for men and women in organisations are influenced by beliefs that domestic commitments are in conflict
with organisational and career demands (Halford et al, 1997). In particular, research findings provide evidence that children have a fundamental impact on the way women are perceived in organisations (Halford et al, 1997).

Working practices which have been defined by 'male' definitions of work and do not reflect non work activities, can also generate sex segregation. This type of organisational culture enforces the ideology that women must choose between motherhood and career (Halford et al, 1997). An example of this provided by Halford et al (1997) who suggest that the move towards performance related culture in some professions benefits workers without domestic commitments. Workers who cannot or do not want to avoid these commitments, namely women, are likely to have difficulty being major players in the organisation. A 'male' organisational culture exists in many organisations which emphasises rational task-orientated behaviour (Ramsey and Parker, 1992) and devalues home and family (Burrell, 1984). Organisational cultures in previously male dominated professions have been developed and sustained by men and are therefore likely to reflect male values. Therefore as I have discussed earlier in this chapter, women have to follow male working patterns if they are to succeed in the occupational structure.

Spencer and Podmore (1987) suggested that women who distance themselves from the norms of the profession, in terms of working part time, choosing not to attend breakfast or late evening meetings and choosing not to work long hours, in preference for a more balanced lifestyle, will not be regarded as dedicated by professional colleagues. In this way organisational culture can result in gender oppression, which
is legitimised by patriarchal process and structures (Ramsey and Parker, 1992).

Recruitment of people who espouse the norms and values of an organisation can particularly generate sex segregation in male dominated professions. Employers tend to recruit people in their own image, who reflect the views and norms of the organisation (Webb and Liff, 1988; Cockburn, 1991). The criteria used in Medicine and other male dominated professions, to assess the suitability of candidates during the recruitment process are male defined (Spencer and Podmore, 1987; Webb and Liff, 1988). In Medicine, senior consultants and the Royal Colleges seem to have a particular person in mind when recruiting new consultants (Silverstone and Ward, 1980). This may disadvantage women or other doctors who do not fit into the conventional model. These structures have also been considered to be influenced by patriarchy (Hartmann, 1976; Walby, 1986, 1990).

2.5.3. Patriarchy in Organisations

It has been argued that the institutional and organisational factors which affect gender inequality are conceptually based on a system of patriarchy (Hartmann, 1976; Walby, 1986, 1990, Witz, 1986, 1992). Walby (1990) describes patriarchy as "a system of interrelated social structures and practices through which men dominate, oppress and exploit women" (Walby, 1990, p.20).

Patriarchy has been considered to be a key influence on gender segregation
Patriarchy as a means of explaining gender segregation in the professions is most useful for explaining organisational structures which segregate women into particular areas of the labour market. Patriarchal influences on gender segregation have been defined by Witz (1986) as strategies of closure and strategies of demarcation. Strategies of closure may be pursued by an occupational group in its attempts to regulate the supply of its own labour, where it takes the form of excluding women from routes of access to resources, such as, skills and knowledge (Crompton, 1987). Closure has also been defined by Parkin (1974, p.3) as "the process by which social collectivities seek to maximise rewards by restructuring access to rewards and opportunities to a limited group of eligibles". Strategies of demarcation are concerned with the creation and control of occupational boundaries. Witz (1986) argues that patriarchal strategies of demarcation have considerable influence on gender segregation in the medical profession.

Previously, patriarchal strategies were primarily exclusionary, where women were excluded from certain occupations, however in recent years they have become more segregationist, whereby women have gained qualifications necessary to enter male dominated professions, but they are segregated within certain sectors of the
profession. Strategies of demarcation and closure are particularly relevant in the medical profession. Witz (1986) describes the medical profession as a profession with well established masculine exclusionary practices, in particular, the predominance of a powerful old boy’s network. Now that strategies are no longer exclusionary, because half of all medical students are women, segregationary strategies provide more relevant explanations for gender segregation in the medical profession. For example, women doctors are under represented in the higher levels of the medical hierarchy (Department of Health, 1996b) and few women doctors attain distinction awards (Gough, 1994).

2.5.4. Individual Choice and Structural Constraints

Within the sociological literature there has been an ongoing debate about whether family structures or labour market structures have the most influence on women’s position in the labour market. However, it is difficult to make clear cut divisions between the issue of choice and constraint. As Walby (1990) argues, examining women’s position in the labour market in the context of their position in the household provides an "understanding of immediate decision making, but it does not provide an explanation of the structures which constrain a woman’s choice" (Walby, 1990, p.56). Purely arguing that women’s employment patterns are based on choice fails to take into account the constraints in which the choice between domestic roles and work roles are made. Women still have primary responsibility for child care and domestic work, which is not by choice but the expectations that are put on women in the family. Therefore women’s choice for paid employment are heavily constrained
by these responsibilities. In this context it has been argued that women’s employment patterns need to be understood as the outcome of both choice and constraint (Crompton and Sanderson, 1990a; Crompton, 1997b).

In the context of gender segregation in the medical profession, issues of personal preference and organisational constraints could be considered to be overlapping. Crompton and Le Feuvre (1996b) provide an example of this when they discuss how "women 'choose' not to enter surgical specialities not only because they are aware of masculine exclusionary practices, but also because of the hours 'on call' during the years of surgical training make any family life very difficult, if not impossible" (Crompton and Le Feuvre, 1996b, p.9). Crompton and Le Feuvre (1996b) suggest that gender segregation in the medical profession is a consequence of choice and constraint (both domestic and occupational).

2.6. New Directions in Equal Opportunity Policies

In an attempt to remove barriers to promotion for women in paid employment, a number of equal opportunity policies have been introduced in the last decade, most notably the Opportunity 2000 scheme (Opportunity 2000, 1991). However, some of these schemes have led to tokenism in the workplace and negative reactions from male colleagues who considered women were receiving special treatment and were primarily getting top jobs because they were women (Opportunity 2000, 1994).

In recent years, feminist sociologists have argued for more fundamental changes to
the structure of paid work, away from equal opportunity policies which focus on women’s 'sameness' (Rubin, 1997) towards a fundamental change in organisational structures (Liff and Cameron, 1997; Rubin, 1997) which recognise that "organisational practices are socially constructed around men’s lifestyles" (Liff and Cameron, 1997, p.36). A change in organisational practices will only occur if opportunities for more flexible working are adopted by men (Webb, 1997). In essence, this will only occur if there is an abandonment of masculine job models as the normal career model (Crompton and Le Feuvre, 1996a) and there is greater acceptance of non linear career paths (Lewis, 1991; Liff and Cameron, 1997). Importantly, if more men are to take up flexible working practices, organisational discourses of time need to change (Lewis 1991, 1997) towards greater acceptance of flexible working practices which are no more detrimental to career progress than full time working practices.

Underlying these changes needs to be an acceptance that work/family issues are not just women’s concern but relevant to both men and women (Dey, 1989; Lewis, 1991, 1997; Evetts, 1994). There needs to be changes to the culture within organisations in order to create greater acceptance for women and men to follow more flexible career paths and acknowledge that both men and women should have a more balanced lifestyle and family life (Itzin and Newman, 1995; Lewis, 1991, 1997; Liff and Wajcman, 1996). Itzin and Newman (1995) argue for more fundamental organisational change to incorporate a consideration of "how the attitudes, beliefs and behaviour of individual men and women, based on ignorance, prejudice and bigotry can be unlearned and replace by egalitarian attitudes, beliefs and behaviour" (Itzin
2.7. Summary

This chapter has provided a summary of previous sociological literature and theoretical debates surrounding women’s employment in professional occupations. In particular, it has highlighted how women’s entry into male dominated professions has been characterised by segregation into particular sectors of these professions. The inter-relationship between employment careers and other aspects of life in shaping women’s employment have been discussed in the research literature on women’s employment patterns. These debates have been supported by empirical evidence in Banking, Local Government, Nursing, Law and Accountancy. The inter-relationship between the employment careers and family life of hospital consultants in understanding the structure of women’s employment in Medicine has been relatively neglected.

Allen’s studies (1988, 1992, 1994) have examined the careers of doctors in which she briefly discussed the effect a medical career had on the personal life of male and female doctors. However, her findings were not analysed in the context of current theoretical debates. In addition, her studies included doctors who followed a wide range of medical careers, many of whom had chosen not to pursue a hospital career because of the organisational culture and working practices in Hospital Medicine (Allen, 1994).
In chapter three I will discuss the research literature on the family roles of professional women, which will highlight the lack of empirical data on the family roles of women consultants in Hospital Medicine and the need for this data in order to better understand how women doctors' family roles influence their employment careers.
CHAPTER 3

Family Roles of Professional Women

3.1. Introduction

The demands of family and child care are perceived to be a constraining influence on the careers of professional women. There have been numerous studies on how women manage the conflict between professional work and child care demands. These studies have focused on how the family roles of professional women differ from the family roles of professional men, on the employment patterns of professional women following childbirth and how gender inequality in the domestic sphere continues to be a constraining influence on professional women's careers. This chapter will discuss this research literature with particular reference to women doctors.

3.2. Marriage and Parenting Patterns in the United Kingdom

Marriage and parenting patterns have changed significantly amongst the population of the United Kingdom over the past thirty years. The mean age for marriage amongst women in 1993 was 26 years and amongst men the mean age was 28 years; a significant increase from forty years ago when the average age for marriage was 21 years for women and 23 years for men (Haskey, 1995; CSO, 1997). These changes reflect a change in the living arrangements of couples as increasing numbers of men and women cohabit, either prior to marriage or with no intention of marriage (Haskey, 1995).
Women are having children at a much later age in the 1990s than in the 1970s. The mean age of birth of the first child among women in England and Wales in 1993 was 28 years, compared with a mean age of 26 years in 1971 (CSO, 1995). In 1992, for the first time more women in their early thirties than women in their twenties were having their first child (CSO, 1995). The numbers of lone parents have also risen. In 1995, 23 per cent of all families with dependant children in the United Kingdom were headed by a lone parent (CSO, 1997). In 1995-96, nearly two fifths of lone mothers were single and a slightly smaller proportion were divorced (CSO, 1997). Lone mothers had younger dependant children than lone fathers, whose youngest child was more likely to be a teenager (CSO, 1995).

3.3. Marriage and Parenting Patterns of Professional Women

Professional women in the United Kingdom, are more likely than professional men to be single and typically delay marriage and childbirth until their careers are well established (Silverstone and Ward, 1980; Corti and Dex, 1995a, 1995b; Wajcman, 1996a). Similar findings have been shown in the United States of America (Cooney and Uhlenberg, 1989). The peak years for career development in most professional occupations are the twenties and thirties (Silverstone and Ward, 1980). By choosing to delay parenting roles, women are able to compete more equally with men at work. The same dilemmas between career and family are not experienced by the majority of professional men.

Professional women are typically married to a partner of similar or higher
occupational status, which has led to the emergence of the dual career couple. Dual career couple refers to couples where both partners have full time continuous careers (Rapoport and Rapoport, 1969, 1976; Bonney, 1988) which are usually in professional or managerial occupations (Gregson and Lowe, 1993, 1994a). Although, there has been a significant rise in the number of dual career couples in recent years, they only represent six per cent of all households in the United Kingdom (Hardill, 1997).

Similar to other professional women, women doctors in the United Kingdom are more likely to remain single than male doctors. The majority of women doctors marry, typically within ten years of graduation (Ward et al, 1981; Stephen, 1987). Women doctors are more likely to marry another doctor and less likely to have children than male doctors (Allen, 1988, 1992, 1994; Parkhouse, 1991; Tait and Plait, 1995). However, in younger cohorts of doctors this trend for women doctors to marry another doctor or another professional is decreasing (Allen, 1994). Younger male doctors are more likely than older male doctors to be married to working women doctors (23 per cent of 1981 medical school qualifiers compared with 16 per cent of 1976 medical school qualifiers) (Allen, 1988).

The majority of women doctors have children but successive cohorts of women doctors have shown that they have delayed having their first child until at least five years after qualification (Jeffreys and Elliott, 1966; Flynn and Gardner, 1969; Ward et al, 1981; Allen, 1988, 1994; Rhodes, 1989). The average age for birth of first child for 1981 and 1985 medical school qualifiers was over twenty nine years (Allen,
1992), which is similar to other professional women and later than the average age amongst women in the population of the United Kingdom. Similar marriage and parenting patterns amongst women doctors have been found in the United States of America (Lorber, 1984; Bowman and Allen, 1985; Uhlenberg and Cooney, 1990).

3.3.1 Dual Career Couples

Interest in dual career couples began in the 1970s when increasing numbers of women entering professional occupations led to the emergence of the dual career couple (Fogerty et al, 1971; Rapoport and Rapoport, 1969, 1979). Aspects of the dual career lifestyle and its effect on women’s careers and domestic life have continued to be of interest to sociologists (Hertz, 1986; Hothschild, 1989; Gregson and Lowe, 1993, 1994b). The dual career couple is an elite group, who are more likely to have the financial resources to better manage the interface between their work and family lives (Gregson and Lowe, 1994a), however women in dual career couples, have been found to suffer from role overload, stress, conflict, little time to spend with partners and no time for themselves (Rapoport and Rapoport, 1969, 1976; Hothschild, 1989).

One aspect facing dual career couples is the need to find two specialist jobs in one particular area. How decisions about migration to new geographical areas for jobs are made is particularly important for the career development of women. Previous studies have found partner’s geographical mobility to have a negative effect on the career development of women (Pahl and Pahl, 1971; Finch, 1983). However, other
studies have found that partner's geographical moves have not led to reduced career prospects for women and conflict only occurs in a small number of dual career households (Bonney and Love, 1991). The effects of geographical mobility on the careers of women are likely to vary according to the type of professional occupation. Some career structures require greater mobility than others, for example, in Medicine and Management, which are likely to create greater difficulties for dual career couples, particularly if both partners are in the same profession.

Some areas of the United Kingdom provide greater job opportunity for dual career couples than others (Green, 1994). In parts of central and outer London and adjacent districts, managerial, professional and associate professional jobs account for over one third of all jobs (Green, 1994). Moves to the South East of England are therefore particularly advantageous for women's careers compared to those of men (Fielding and Halford, 1993).

Previous research has shown that geographical moves amongst couples are almost never made to benefit the woman's career alone, although they may be made to benefit the man's (Rapoport and Rapoport, 1976). Research on dual career households (Green, 1994; Hardill et al, 1997) found various different patterns for geographical moves amongst dual career couples. In cases where there was a 'lead' career, this person's career had not always been dominant throughout the couple's work history, and it was not always the man's career which was dominant. Women were more likely to be the 'follower' amongst older partners in dual career couples. This study also found evidence of 'dual location' households where one partner (usually the
male) commuted to the family home at the weekends and lived nearby his/her work during the week (Green, 1994; Hardill et al, 1997). The difference in partner’s employment status was also found to have an impact on geographical mobility; working wives inhibited male career migration more than non working wives (Bruegel, 1996a).

There has been limited research on geographical mobility patterns of doctors in the United Kingdom, which is surprising given the high levels of geographical mobility required during the training years of a medical career. The career structure of Hospital Medicine, in particular, requires a high degree of mobility during the training years (see chapter one), which has historically reversed at the end of training where consultants are typically in the same post for the rest of their working life, although this is changing with more contractual posts and job insecurity at consultant grade.

The work of Johnson et al (1992) is the only study in the United Kingdom to examine the relationship between geographical mobility and career development for dual doctor couples. Johnson et al (1992) found that in dual doctor marriages, the man’s career takes preference while women were more likely to interrupt their careers during child rearing and work part time. Elliot’s study (1981) of male junior doctors with non working wives, found evidence of frequent mobility for jobs which had a negative effect on the partners and children of male junior doctors.

Allen (1994) examined doctor’s attitudes towards the necessity for geographical
mobility and she found that the need for geographical mobility was the second
greatest constraint on doctor’s careers. The need for geographical mobility caused
difficulties for doctor’s personal relationships and family life, and caused difficulty
in managing the careers of dual career partnerships. Other studies have shown that
consideration of spouse’s employment is a greater constraint on the careers of women
doctors than male doctors (Newcastle Branch of Women In Medicine, 1983;
households’ was found amongst female surgeons in Scotland, whereby women
surgeons were living away from their partners because of their jobs (Maran et al,
1993).

While marriage to another professional has its difficulties, marriage to someone in the
same profession has been shown to be beneficial to managing the dual career lifestyle
(Hall and Hall, 1979; Lorber, 1984). In particular, by providing a source of
professional information, shared workloads and job shares, the role overload
experienced by dual career couples is decreased. However this was not found in all
professions, such as Accountancy, where husbands and wives were prevented from
working in the same firm (Hall and Hall, 1979).

3.4 Professional Women’s Employment Patterns Following Childbirth

Research on the working patterns of women following childbirth has shown that the
majority of women in the United Kingdom work part time after the birth of their first
child or take a career break (Martin and Roberts, 1984; Brannen et al, 1994; Glover and Arber, 1995; CSO, 1996). The working life of most women in the United Kingdom is discontinuous with periods out of the labour market or lower involvement in the labour market during the child bearing years. However, mothers in professional and managerial occupations are more likely to return to full time paid work after the birth of their first child (McRae, 1993; Harrop and Moss, 1994; Glover and Arber, 1995; Macran et al, 1996).

Women who are highly qualified tend to return to work more quickly after childbirth than women who are less qualified (Fogarty et al, 1971). Over half of women in professional or managerial occupations compared with a third of women in other occupations return to work within nine months of the birth of their child (McRae, 1991). Mothers working in professional occupations with babies under a year old are twice as likely (21%) as women in manual occupations (9%) to be working full time (Glover and Arber, 1995) and two thirds of mothers in professional or managerial occupations who have children under five years are employed (Brannen et al, 1994). Consequently a significant proportion of women in professional occupations have two roles, work and family.

The working patterns of professional women reflect the working practices in male dominated occupations which emphasise the need for full time continuous careers (see chapter two). Women in male dominated professions often do not want to be seen to be getting special treatment and want to compete with men on equal terms and therefore they adopt strategies to ensure that minimal disruption occurs to their
employers as a result of them becoming mothers (Lewis and Cooper, 1989). However this has some cost in terms of personal stress, tiredness and reduced time for themselves (Brannen, 1989).

3.5. Women Doctor’s Employment Patterns following Childbirth

Studies have shown that the number of women who permanently leave the medical profession is small (Allen 1988, 1994; Parkhouse, 1991; Bolton-Maggs et al, 1988). Allen’s study of 1966 qualifiers showed that only seven per cent of women doctors had given up medical practice for good or for a long period of time because of children. Instead, women take short career breaks (Maddock and Parkin, 1994), about a quarter work part time and the remainder work full time after the birth of children (Allen, 1988).

Women doctors who take career breaks do so typically for a short period and take them at a later stage in their career (Jefferys and Elliott, 1966; Beaumont, 1979; Elston, 1980; Ward et al, 1981; Allen, 1988; Parkhouse, 1991; Rhodes, 1990; Parkhouse and Parkhouse, 1989). Older cohorts of women doctors (1949-1951 qualifiers) typically had a longer break from Medicine than younger cohorts of women doctors (Ward et al, 1981). Career breaks early in a career have been associated with downward mobility of highly qualified women (Dex, 1984). Women medical school qualifiers in the 1960s and 1970s typically took career breaks ten years after qualification which is a later stage in their career than earlier cohorts of
women doctors (Elston, 1980; Ward et al, 1981; Allen, 1988). Trends amongst younger women doctors, indicate that they typically remain in Medicine after childbirth and the majority work full time (Allen, 1994), but younger women doctors with children are likely to do less on call work than their male colleagues (Swanson, 1996).

One factor influencing retention is the wide range of medical fields available in medical careers, some of which are more compatible with family life, than others. Successive studies have shown that women doctors have chosen careers in General Practice rather than in Hospital Medicine because of greater opportunity to combine motherhood and professional work (Lefford, 1987; Elston, 1980; Parkhouse, 1991; Allen, 1988, 1992). However, women doctors who pursue careers in Hospital Medicine are increasingly marrying and having children. Employment patterns of female hospital doctors after childbirth are important in highlighting how motherhood and a career in Hospital Medicine can be combined, without being detrimental to career progress. Taking a career break was not detrimental to career progress for women doctors who had achieved consultant grade in clinical oncology (Junor and Barett, 1993).

Women doctors who become mothers during training have to combine motherhood with the demands of a 72 hour working week, including heavy on call commitments, some of which will be resident on call in the hospital. Women who delay childbirth until consultant grade, have greater opportunities to work part time without this being detrimental to their career progress. However the demands of a consultant post are
increasing and the balance between work and family is likely to be difficult for consultant mothers with young children, particularly if their partner has a demanding career as well. Research studies on doctors in the United Kingdom have focused on doctors in training and have therefore not been able to examine how women who become mothers at consultant grade manage the interface between their careers and motherhood, and how this differs from women who have children during training.

3.6. The Dual Roles of Professional Worker and Mother

Following the Industrial Revolution there was a separation of the work and family spheres (Weber, 1947), gender roles in the family were segregated into the primary role for women as homemaker and primary role for men as breadwinner. With women's increased entry into paid employment these traditional boundaries have become less clear and many women now have two roles (Pleck, 1977, 1985). However ideologies surrounding the appropriate gender roles of men and women in the family persist.

The dominant ideology of motherhood is of a full time mother who stays at home, at least while her children are of preschool age (Lewis, 1991). This ideology of appropriate gender roles in parenthood have led to criticism of working mothers within the psychology literature and the media (Bowlby, 1953; The Sunday Times, 1997; The Guardian, 1997). Working mothers have been criticised for the deprivation of their child's well being (Bowlby, 1953). This criticism of maternal deprivation, which began in the 1950s when women first entered the labour market,
has risen intermittently over the past four decades, particularly against women who work full time or who are highly committed to their careers. The debate began with Bowlby (1953) arguing that if a child was separated from it's mother during the first three years of life, the emotional well being and development of the child would be affected. In response to this argument psychologists have emphasised the importance of familiarity and continuity in the early years of a child’s life, which did not necessarily need to be provided by the mother (Tizard, 1986; Lewis, 1997). Further arguments against Bowlby’s argument have been documented by Tizard (1991).

However, criticism of full time working mothers has continued to be an area for controversial debate, which has only helped to nurture feelings of conflict experienced by some working mothers (Lewis and Cooper, 1989; Brannen and Moss, 1991, 1992). Yet working fathers have rarely received the same criticism. It is only in recent years that traditional ideologies of fatherhood have been questioned and the involvement of fathers in parenting has become more topical (Miles, 1997; Ferri and Smith, 1996; Burghes, Clarke and Cronin, 1997).

Ideologies of parenthood in our society are constructed around greater acceptance of the work commitments of fathers than the work commitment of mothers, largely because men are still viewed as the primary breadwinner (Lewis, 1991). Women who work full time and are committed to their career face conflict in their dual roles. They are criticised for not being an 'ideal' mother but if they modify their working arrangements they face discrimination for presumed lack of commitment to their work, because organisations are based on male working practices (see chapter two)
Attitudes towards parenthood in organisational cultures are disadvantageous to women because marriage and children are considered a drain on women’s commitment to paid work, but marriage and children are beneficial factors for the career development of men (Collinson, 1988; Halford et al, 1997). Halford et al, (1997) argue that negative attitudes towards motherhood in organisational cultures lead to assumptions that career women are expected not to have domestic commitments if they are to meet the demands of organisational life or if they do have domestic commitments, they are perceived to have lower commitment to their paid work than women without children (Halford et al, 1997).

In addition, professional women who have invested human capital in their career are less likely to want to be a full time mother, and even if they wished to, they are criticised for wasting the investment in their training (Johnson and Johnson, 1980). Professional women are increasingly likely to adapt to male orientated working practices, rather than changes being made in employment practices which benefit professional women and men with children. This results in the 'superwoman syndrome' (Newell, 1993) whereby women try to excel in their careers and in motherhood. However, Lewis (1991) has described this ideology as oppressive "because it implies that women can comply with the cultural prescriptions of a good mother and a good worker without modifying the demands of either" (Lewis, 1991, p.197).

The conflict between work and parenthood as experienced by women doctors has been well documented (Lunn, 1964; Elliott and Jeffreys, 1966; Stanley and Last, 1968;
Flynn and Gardner, 1969; Whitfield, 1969; Aird, 1971; Shaw, 1979; Swerdlow et al, 1980; Rhodes, 1989; Firth-Cozens, 1991; Bynoe, 1992, 1994). Many of these studies have been taken at specific periods of time, or relate to women from particular medical schools and most refer to aspects of marital status, parity and age of children, and focus on women doctors’ career patterns, in terms of lack of part time opportunities (Swerdlow et al, 1980; Rhodes, 1989), or how career patterns are restricted because of husband’s career and child care demands (Henryk-Gutt and Silverstone, 1976; Ward et al, 1981; Swerdlow et al, 1980; Rhodes, 1989). The stress experienced by women doctors who combine a medical career with motherhood has also been documented (Godlee, 1990; Firth-Cozens, 1991; Bynoe, 1992, 1994).

Previous studies do not provide detailed information of how family demands have been managed by women doctors who achieve senior grade in Hospital Medicine. Tait and Platt’s (1995) research is the only study which has focused primarily on women who have achieved consultant grade in Hospital Medicine. Their postal questionnaire of a large sample of NHS women consultants showed women perceived that being flexible in their choice of speciality, being very well organised, having a healthy family and a supportive partner and reliable full time or live in child care arrangements were important factors in achieving consultant grade. Achieving consultant grade also had some costs to women consultant’s personal life, in particular divorce and difficulty conceiving, which women consultants had associated with the stress of their medical career (Tait and Platt, 1995). However, the findings from this study are limited because of the methodology used. More detailed information on the factors described above could not be collected because a postal questionnaire was
used. The most detailed large scale information on doctors work and family lives is found in Allen’s studies (1988, 1992, 1994). However, these studies addressed a range of issues and therefore the inter-relationship between work and family life is not examined in any depth.

The conflict between work and parenthood as experienced by male doctors has been a neglected area of research. There has only been one study which focused specifically on the conflict between work and family for male junior hospital doctors in the United Kingdom (Elliott, 1979). Elliot’s (1979) study focused on junior male doctors with non working wives. The findings indicated that male junior doctors had little involvement in family life which led to an unequal division of labour, isolation for partners and a negative effect on relationships with their children and their partners (Elliot, 1979, 1981). Allen’s studies (1988, 1992, 1994) examined the careers of doctors in the United Kingdom and examined briefly the conflict between the work and family lives of male doctors. She found that younger male doctors wanted to have greater involvement with their families and were dissatisfied with the on call commitment and long hours which were taking them away from their families (Allen, 1994).

3.7. **Unpaid Work in the Home**

Sociological interest in increasing numbers of women in paid employment has been combined with a parallel interest in the effect that women’s employment has had on the traditional roles of men and women in the family. This interest began in the
1970s when Young and Willmott (1973) suggested that the increase in women’s employment would create a more egalitarian and symmetrical family whereby husbands and wives would equally share the division of labour in the household. However, in the late 1980s and 1990s, research studies (Pahl, 1984; Morris, 1990; Wheelock, 1990; Warde, 1990) have shown that a variety of arrangements for domestic labour amongst households are used (Yeandle, 1984; Wheelock, 1990; Warde and Hetherington, 1993) and these vary according to the structure of households (Gregson and Lowe, 1994a). Men are more involved in domestic labour and child care than they were thirty years ago (Gershuny et al, 1994). However, women are also doing less domestic labour, but marginally so, compared with men. Women are still primarily responsible for organising and undertaking domestic labour and child care, even when they work full time (Brannen et al, 1994; Gershuny et al, 1994; Gershuny, 1995).

Variations in the domestic division of labour exist according to family structure, for example, both mothers and fathers with young children are more involved in domestic labour than women and men in other family structures (Pahl, 1984; Witherspoon, 1985). Fathers in dual full time earner families are more likely than those in other family structures to share domestic labour and child care with their partners (Ferri and Smith, 1996). Mothers who work part time are more likely than full time working mothers to be responsible for child care (Ferri and Smith, 1996). Well educated partners and those with less traditional sex role beliefs are also more likely to contribute to housework and middle class men are more likely to participate in the household than working class men (Ross, 1987). Fathers with employed partners are
more involved in domestic labour than fathers whose partners are not employed (Brannen and Moss, 1991; Brannen, 1989). Unemployed men have greater involvement in domestic labour and child care if their partner works full time (Wheelcock, 1990; Morris, 1990) however being unemployed did not lead to a substantial increase in the amount of domestic labour men undertook (Morris, 1990; Tyrell, 1995).

The domestic division of labour debate has taken on a new focus in the context of dual career couples, where both partners are working full time in demanding jobs. The context in which the dual career family is established should theoretically result in greater equality in the sharing of domestic labour and child care. However equal attachment to employment does not translate to equality in domestic roles (Brannen and Moss, 1992). Although men in dual career couples do more domestic labour and child care than men in other family structures, women in dual career couples are just as likely as women in other occupational groups to be responsible for the overall management of domestic labour and to have greater involvement in child care than their partners (Brannen, 1989; Gregson and Lowe, 1993, 1994b; Wajcman, 1996a).

Amongst professional women and dual career couples there is an increasing trend to hire paid labour to undertake domestic tasks (Hertz, 1986; Gregson and Lowe, 1993, 1994b; Brannen, 1989). The transfer of household work on to individuals who are paid to carry out this work is an important part of managing the relationship between employment and family life for professional women. This growing trend indicates that even amongst dual career households, domestic labour is not shared equally
between partners. Instead alternative strategies are used to overcome gender inequality in the home. However, paying other women to undertake domestic labour perpetuates a process which devalues housework and requires women to work within male working practices and structures, in order to seek equality with men (Hothschild, 1989).

The research studies on the domestic division of labour, highlight evidence of gender stereotyping of particular domestic tasks (Pahl, 1984; Warde and Hetherington, 1993; Gershuny et al, 1994, Brannen et al, 1994; Gershuny, 1995). The work women do in the household tends to be cleaning, cooking, laundry etc, whereas the majority of work men do in the household is household repairs, gardening etc. Although men with employed partners do more child care tasks than men whose partners are not employed (Brannen, 1989), men are generally more involved in leisure aspects of child care such as play and outings rather than mundane daily tasks which are generally undertaken by women (Wheelcock, 1990, Brannen and Moss, 1991).

Paid child care in the form of nannies or au pairs are used extensively by women in professional or managerial occupations (Brannen, 1989). Child care arrangements are an individual’s responsibility in the United Kingdom. Compared with other European countries, state support for women seeking to combine work and family is poor in the United Kingdom (Brannen et al, 1994). The organisation of child care amongst working couples is largely undertaken by women (Brannen, 1989; Brannen and Moss, 1991). The unpredictable nature of child care, such as illness, or doctor’s appointments, can be particularly difficult for professional women who are working
in occupations where it is not possible to leave work in a family emergency. Unpredictable child care events are also primarily undertaken by women, or in the minority of cases undertaken by both parents but rarely undertaken solely by men (Brannen, 1989; Ferri and Smith, 1996).

Reasons given by women for their greater involvement in the organisation of domestic labour and child care are closely associated with traditional gender ideologies in the family. In particular, women considered child care arrangements to be a mother’s responsibility (Rapoport and Rapoport, 1969; Brannen, 1989; Hothschild, 1989) or in cases where women were of higher occupational status than their partners, traditional gender roles in the family were maintained to reinforce images of the good wife and mother and the husband as head of the household (McRae, 1986). These traditional attitudes towards the division of responsibility in the home remain dominant even in households where women work full time (Newell, 1993). Explanations for this gender inequality by Oakley (1982) suggests that the cultural ideology prevalent in society views housework as women’s work and cultural socialisation and expectations reinforce the view that women can do these tasks more naturally than men.

The emotional labour involved in raising children is a relatively neglected area in the domestic division of labour literature. Nicky James in her articles on emotional labour (1989,1992) has given a new dimension to the inequality of domestic labour debate. She defines emotional labour as "the labour involved in dealing with other people’s feelings" (1989, p.15). It involves ensuring that the emotional needs of
children, partner and other relatives are met. Women are strongly associated with caring (Morris, 1990; Wheelcock, 1990) and as a consequence women are primarily held responsible for emotional labour, particularly for their children (James, 1989). James (1989, 1992) argues that emotional labour is an undervalued aspect of domestic labour and has largely been invisible and unrecognised in the domestic domain. She says, "because emotional labour is seen as natural, unskilled women’s work, because it is unpaid and because it is obscured by the privacy of the domestic domain where much of it takes place, the significance of it’s contribution and value in social reproduction is ignored" (James, 1989, p.22).

Emotional labour is extremely taxing and time consuming because it requires flexibility and appropriate responses according to different situations and different needs. It is about "action and reaction, doing and being" (James, 1989 p.500) and unlike other forms of domestic labour it is unpredictable and cannot be organised into a timetable (James, 1989). Women are primarily held responsible for emotional labour because of their perceived 'natural skills' for this type of work (James, 1989). Hence emotional labour, like other aspects of unpaid work has been characterised as women’s work and in doing so contributes to the perpetuation of gender inequality in the domestic sphere.

3.8. Doctors and the Domestic Division of Labour

Data on the division of domestic labour and child care amongst doctors has largely come from the United States of America (Bowman and Allen, 1985; Weisman and
Teitelbaum, 1987; Uhlenberg and Cooney, 1990; Tesch et al, 1992; Brotherton and LeBailly, 1993). There has been a significant gap in the research literature on the child care and domestic labour patterns of doctors in the United Kingdom. In particular there have been no studies on hospital doctors, in terms of how hospital doctors manage child care demands and how this effects the careers of male and female doctors.

Studies in the United States of America indicate that women doctors, take responsibility for domestic labour and child care and are likely to adjust their professional work to their family demands, even when their partner is also a doctor. Weisman and Teitelbaum (1987) found that women in dual doctor couples had more responsibility for the organisation of domestic labour. Work and family roles were closely associated with traditional gender roles. Women in dual doctor couples reduced their work roles because of their family roles, but the same did not occur for male doctors. Tesch et al (1992) in their study of women doctors found that women doctors married to doctors generally undertook a greater share of the domestic labour and child care, interrupted their career to accommodate their partner’s career and worked fewer hours than women doctors married to non doctors. Brotherton and LeBailly (1993) found in their study of paediatricians that marriage to a doctor and presence of children affected the career decisions of female paediatricians. Male paediatricians in dual doctor couples had shorter working hours than male paediatricians married to a non doctor.

The only research on this subject in the United Kingdom is by Allen (1988) which
showed that male doctors in training at the time of this research were more likely than previous cohorts of male doctors to be part of a dual career couple or a dual earner couple (Allen, 1994). Recent male medical school graduates consider children to be a constraint on their career and are increasingly prepared to share their domestic responsibilities with their partners (Allen, 1994). However, there is very little detailed information on how male and female doctors resolve child care demands or how the relationship between their professional work and their family demands is managed over the whole span of their careers. In particular, there is no information on how different family structures affect the interface between work and family for male doctors compared with female doctors. There is also limited information on women doctors' attitudes towards motherhood and childrearing or how children and marriage provide social support as well as a constraint on careers, as Bynoe (1992) found in her study of consultants and senior registrars in the Yorkshire Region.

Women doctors, like other professional women, use paid help with domestic labour and child care. A variety of childminders and nannies are the most common type of child care used (Allen, 1988), however the unpredictable long hours that doctors are required to work means that good child care is likely to be costly. The need for good child care arrangements are particularly important for dual doctor couples where both parents are susceptible to the unpredictable demands of on call cover. Even if women doctors work part time hours to accommodate their child care demands, the need for extensive child care arrangements exist because part time training in Medicine still involves a working week of up to thirty hours, as well as an on call commitment. How this is managed by doctors and the effect this might have on
women's careers has not been studied in the United Kingdom.

3.9. **Summary**

The research literature shows that the family and parenting patterns of professional women are closely associated with their paid employment. Professional women manage their family roles in a number of ways, to enable them to return to full time work shortly after childbirth and maintain a full time continuous career. Gender inequality in the domestic division of labour persists amongst professional women, even amongst dual career couples where both partners are working full time. The research literature suggests that the relationship between work and family roles of professional women is complex.

There has not been a detailed study of the relationship between work and family for hospital doctors in the United Kingdom. Allen's studies (1988, 1992, 1994) primarily focus on doctors in training, while providing valuable information on current trends, they do not provide information on doctors working and family lives over the whole course of their careers and life span. Under researched areas include how different family structures affect the interface between work and family and how this differs for male and female doctors. Previous studies of doctors in the United Kingdom generally focus on women, or variations between women and men, and tend to treat all male doctors and all female doctors as homogenous groups. Variations in the relationship between work and family life for women doctors according to different medical specialities is a neglected area of research. Further information on these
issues will provide a better understanding of the interface between work and family life for hospital doctors and how this effects the career patterns of women doctors.
CHAPTER 4

Methods

4.1 Aim of the Research

The overall aim of this research is to examine gender differences in the inter-
relationship between the professional life and the family life of hospital consultants
in the United Kingdom, in terms of how this relationship affects the employment
careers of male and female consultants. In particular, for women, how the inter-
relationship between professional life and family life is associated with horizontal
segregation between specialities and vertical segregation within the consultant grade.
Within this context, four research questions are addressed.

4.2 Research Questions

1) How do 'male orientated' working practices and a 'male' organisational
culture, affect the family life of male and female doctors who achieve
consultant grade in Hospital Medicine?

2) How does the relationship between family structure and the work/family
interface differ for male and female consultants, and according to medical
speciality?

3) What strategies are employed by male and female consultants to manage the
4) Are different strategies employed by consultants in different medical specialities, and why are these differing strategies employed?

4.3 **Context of the Research**

This study included hospital consultants aged forty to fifty years working in NHS hospitals in South Thames Health Region during mid 1995. Hospital Consultant was the only medical grade selected because the aim of this study was to focus on 'successful' doctors, to identify how the relationship between career and family life is managed amongst doctors who have achieved consultant grade within their profession. Previous research has examined the experiences of doctors in training grades (Allen, 1988, 1992, 1994; Parkhouse and Parkhouse, 1991).

4.3.1. **Area of Medical Practice**

The focus of this study was Hospital Medicine. Hospital Medicine is considered to be the toughest path to a career grade in the medical profession. There are a number of reasons including: the long period of training, which coincides with the peak childbearing years; the need to take higher professional exams and to undertake research and publish papers; the long working hours and on call commitment; the limited opportunities for flexible working practices; and the predominance of a male dominated 'macho' culture. The inter-relationship between professional life and
family life is therefore likely to be more complex for male and female doctors who achieve consultant grade in Hospital Medicine than for doctors in other areas of medical practice.

Doctors in General Practice and Public Health Medicine were not included for a number of reasons; (i) the career structure in General Practice and Public Health Medicine is different from Hospital Medicine, in particular, it is considerably shorter; (ii) in both General Practice and Public Health Medicine there are shorter, more flexible working hours, (iii) there have historically been a higher proportion of women working in General Practice and Public Health Medicine than Hospital Medicine.

The structure of specialist medical training is currently undergoing a radical overhaul as discussed in chapter one. The creation of new training structures will completely restructure the career patterns of doctors working in Hospital Medicine in the future. This study will provide baseline information about the professional and family life of doctors who have achieved consultant grade in Hospital Medicine and trained within the old medical career structure. This baseline information will enable comparisons to be made with future research which examines the career and family life of doctors who train under the new hospital medical career structure. It is therefore timely to examine the careers and experiences of doctors who have attained consultant grade in Hospital Medicine.
4.3.2. **Age Group**

Restriction of the age range to between forty and fifty years was made according to key career and family life events. Forty years was set as the youngest age for inclusion in the sample for four main reasons;

1) the majority of doctors will have completed their medical training and would be working as a consultant by the age of forty. Previous research indicates that the average age a consultant post is achieved is between 34 and 36 years (Allen, 1988).

2) consultants aged between forty and fifty years are likely to have reached the highest points in their professional careers;

3) by the age of forty, the majority of female consultants will have either had children or decided if they are not planning to have children;

4) consultants who have taken a career break are likely to have returned to medicine by the age of forty.

Fifty years was selected as the oldest age for inclusion in the sample because doctors who are currently aged over fifty years began their medical training prior to the 1960s. Therefore, they trained before women entered the labour market in any substantial number, when there were few women in medical training and few, if any,
women in senior positions in the medical profession and when the majority of women left employment at marriage. On this basis, the experiences of the men and women aged over fifty, may be very different from doctors aged forty to fifty years.

4.4. Choice of Method

There were four main choices that could be made for the data collection method. These were (i) postal questionnaire; (ii) structured interview, (iii) in depth interview or (iv) semi structured interview.

4.4.1. Postal Questionnaire

A postal questionnaire was not considered a viable option for this study. In recent years, with the increase in providers of services undertaking evaluation and audit of their services, together with the growth of health services research, doctors have been overwhelmed with the number of surveys and questionnaires they are asked to complete in the course of their work. As a consequence there can be a low response rate from postal questionnaires sent to doctors. Moser and Kalton (1975) state that a postal questionnaire

"can be considered only when the questions are sufficiently simple and straightforward to be understood with the help of printed instructions and definitions" (Moser and Kalton, 1975, p.260).
In addition, some of the data to be collected were very detailed and complex, particularly information about work histories and the domestic division of labour. To adequately answer the research questions it was necessary for respondents to be reflective about their career and family life, which is not possible in a self completion questionnaire. A postal questionnaire would limit the opportunity to elaborate on answers, to overcome ambiguous answers and to overcome any unwillingness to fill in more complex parts of the questionnaire.

4.4.2. Structured Interview

A structured interview was also not considered the most effective method. Although, much of the information required was factual and therefore could be collected through the use of a structured interview schedule, one of the aims of the study was to identify reasons for the type of relationship between professional and family life, including the values that doctors put on this relationship. This information could be most effectively collected through detailed probing using open ended questions. Therefore the interview schedule needed a number of open ended questions to enable these issues to be addressed.

4.4.3. In Depth Interview

Data collection by in depth interview was not considered appropriate for two reasons. Firstly, analysis of information about work history and domestic division of labour would be difficult with a format which was totally open ended. Secondly, one of the
aims of the study was to compare across hospital medical specialities, therefore, there was a need to study a large enough sample to draw conclusions that were statistically significant.

4.4.4. Semi Structured Interview

In this context, the most appropriate method of data collection was the semi structured interview. It was not possible in the time available for me to undertake all the interviews, therefore four interviewers were employed for the study. This may have led to problems of reliability of the interview data. Some of the problems with the reliability of semi structured interviews have been highlighted by Shipman (1981).

"The interview can be more flexible than the questionnaire, it can probe deeper, can be adjusted to circumstances, can increase rapport and cooperation but the cost may be a reduction in control and consequentially in reliability" (Shipman, 1981, p.95)

The methods used to increase the reliability of the results are discussed later in this chapter. While it was recognised that reliability of the results may be lessened, the opportunity for using semi structured interviews to probe in depth and clarify issues was important.
4.5. Developing the Framework of the Research

The early stages of the research involved discussions with Isobel Allen at the Policy Studies Institute and academic staff at St. George’s Hospital Medical School. These discussions provided background information about the key issues affecting the career paths of doctors in the medical profession. A number of key themes were prevalent throughout the discussions and a review of the literature identified similar issues. These were (i) the interface between work and domestic life; (ii) issues affecting career development in Medicine; (iii) the environment and organisational culture within Medicine and (iv) career achievement and job satisfaction.

A systematic review of the medical and sociological literature was undertaken using Sociofile, Medline (1975-1997), Assis and Cinhal (1982-1996). A review of European and International medical sociology conference abstracts was also undertaken. The literature in the following areas was reviewed; medical careers in the United Kingdom and abroad; gender and work; dual career households; the domestic division of labour; sociology of the professions and women in male dominated professions.

4.5.1. Qualitative Interviews

Knowledge of the environment in which this study would take place was needed before the data could be collected. It was important to be familiar with key issues and relevant terminology before the interview schedule for the main study could be
developed. One method of doing this is to undertake in depth qualitative interviews. Walker (1985) states that

"the depth interview is a conversation in which the researcher encourages the informant to relate, in their own terms, experiences and attitudes that are relevant to the research problem" (Walker, 1985, p.4).

The qualitative interviews were undertaken with five senior registrars and consultants in Public Health Medicine at South Thames Regional Health Authority and at St. George's Hospital Medical School. These qualitative interviews which took place during the early stages of the research were important in providing information to develop a semi structured interview schedule. This ensured that the schedule was based on issues relevant to doctors and provided information on appropriate response formats for the interview schedule.

A interview guide was used for the qualitative interviews (Appendix 1). The interview guide included a number of open ended questions, with the main aim being to elicit from respondents key issues and experiences surrounding the broad area of professional and family life.

4.6. Geographical Location of the Research

South Thames Regional Health Authority, who provided funding for this research, were interested in information relating to their particular Health Region, therefore this
study took place in the South Thames Health Region. South Thames Health Region is one of the eight NHS regions in England and it covers a significant proportion of the South East of England including Kent, Sussex, Surrey and parts of the south west and south east districts of London (Appendix 6).

In order to estimate to what extent the findings of the research could be generalisable to other parts of the country, the characteristics of South Thames Region as an area of study have been compared with other health regions in England and Wales. Doctors working in South Thames Region may have different experiences, for a number of reasons, to doctors working and training in other parts of the country. For instance, there are a greater number of acute hospitals and community hospitals in South Thames Region, than in some other regions of England and Wales (Table 4.1). This may lead to greater job availability which would have particular benefit for dual doctor couples.
Table 4.1. Proportion of Acute Hospitals, Specialist Hospitals and Community Hospitals by NHS Region in England and Wales in 1995

<table>
<thead>
<tr>
<th>NHS Region</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern and Yorkshire</td>
<td>53</td>
<td>(17)</td>
</tr>
<tr>
<td>North West</td>
<td>48</td>
<td>(15)</td>
</tr>
<tr>
<td>South Thames</td>
<td>48</td>
<td>(15)</td>
</tr>
<tr>
<td>North Thames</td>
<td>41</td>
<td>(13)</td>
</tr>
<tr>
<td>Anglia and Oxford</td>
<td>37</td>
<td>(12)</td>
</tr>
<tr>
<td>Trent</td>
<td>35</td>
<td>(11)</td>
</tr>
<tr>
<td>West Midlands</td>
<td>31</td>
<td>(10)</td>
</tr>
<tr>
<td>Wales</td>
<td>25</td>
<td>(8)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>318</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Source: IHSM (1994)

The geographical area covering South Thames Region is also very concentrated, compared with other regions, for example South and West Region and Northern and Yorkshire Region. This is likely to provide greater opportunity for commuting from home to work without having to move to a new geographical area because of greater travelling distance between home and new job opportunities. As a consequence junior doctors could, theoretically, spend their whole training period in one geographical region, which reduces the impact of geographical mobility on doctor’s relationships and families. The South Thames Region covers a significant proportion of outer London districts and some parts of central London. In parts of central and outer London and adjacent districts, managerial, professional and associate professional jobs account for over one third of all jobs (Green, 1994). Therefore doctors in dual career partnerships are likely to benefit from greater opportunity for both partners to find jobs in the same area. In other geographical areas, doctors may need to be more
geographically mobile, which is likely to be a greater problem for women doctors who are likely to find it more problematic to disrupt their husband's career compared with male doctors disrupting their wives' careers by moving to another area. As a result there may be higher numbers of dual full time career couples in the sample than if the research had been undertaken elsewhere in the country.

4.7. **Content of the Interview Schedule**

The interview schedule included a mixture of open ended and fixed response format questions. There was a need to include a number of fixed response format questions to help with coding because the sample was reasonably large. However certain topics, such as the effect of a medical career on family life, were sensitive and therefore benefited from open questions with the opportunity to probe for more detailed information. The response format for the fixed response questions was developed from the answers given during the qualitative and pilot interviews.

The interview schedule included five main sections; Section A- Work history of respondent, Section B,C,D,E - Domestic life (separated according to marital status), Section F - Postgraduate training, Section G - Environment in the medical profession during postgraduate training and Section H - Medical achievement (see Appendix 2).

**Section A - Work History**

This section included questions about periods of part time work, career breaks,
working abroad, periods of unemployment, periods working outside Medicine and reasons for choice of speciality. The aim of this section was twofold; (i) to examine cases where consultants had or had not followed a linear career path, and what the effect had been on their subsequent career progress; (ii) to identify consultants who had wanted to work part time, take a career break or work abroad during their training and to examine reasons why they were unable to do so. Questions were asked about choice of speciality to examine the factors which influenced the final choice of speciality.

Sections B, C, D, E - Domestic Life

Sections B, C, D, and E included questions about domestic life. Each section referred to a different marital state, single (section B), married/cohabiting (section C), previously married/cohabiting (section D) and divorced/widowed (section E). Consultants were only asked questions from the section relating to their marital status at the time of the interview, although if they had more than one marriage or long term cohabitation they were also asked section D relating to their previous relationship. Section C, D and E included questions about partner’s support for the consultant’s career, questions about children including a detailed section on how childrearing responsibilities are shared between partners, paid child care and informal child care (by friends, neighbours or relatives). Questions about how household tasks are shared between partners, paid domestic support and support from relatives were also included. Section B included questions about children, including child care arrangements and informal child care support. In each section, questions were also
asked about the effect of family life on career progression and the effect of a medical career on family life.

Included within the domestic life section was a work and life history grid which was used to record key work and family events for each consultant for every year from the first year of medical school (or in the case of overseas doctors from the year they started training in the United Kingdom) until 1995. The following information was collected for each consultant; medical grade, speciality, place of work, employment status, marital status, birth of children, place of residence for the consultant and his or her partner(s) during their relationship(s)/marriage(s), and partner's occupation, employment status and place of work. The aim of the work and life history grid was to collect a chronological account of each consultant's work and life history to enable variation by gender to be analysed.

Section F - Postgraduate Medical Training

Section F included questions about postgraduate medical training. This included six main areas; geographical mobility, research opportunities, promotion through the medical grades, support from senior colleagues in furthering their career, the career structure, and the effect of long working hours on life outside Medicine.

Questions were asked about postgraduate training to establish what factors had been influential in determining career paths. Questions about career structure, geographical mobility, promotion through the grades were asked to identify any
difficulties consultants may have encountered in reaching senior grades in their speciality. Questions about help from senior colleagues in furthering their career were important in identifying evidence of patronage. Questions about working hours during postgraduate training and life outside Medicine were asked to identify whether long working hours had any influence on consultant's choice of speciality and also to examine the effect long working hours had on developing and maintaining steady relationships. The latter was considered important because long working hours could influence marital status and could have a substantial effect on domestic life. Questions about research opportunities were asked because research publications are an important factor for career development in some areas of Medicine. It was therefore important to examine the opportunities consultants had during their training to undertake research and the influence this had on their career path and their achievement in reaching consultant grade in the medical profession.

Section G - Medical Environment During Training

Questions about the culture within the medical profession at the time consultants were training were asked in Section G. Three main themes were included; predominance of male or female colleagues during training; attitudes towards women doctors; and awareness of expected codes of behaviour in Medicine. The medical workforce has changed considerably since the time the consultants in the sample were training. During the 1960s and 1970s, the number of female junior doctors and female consultants was small (see chapter one). The level of competition amongst specialities was also different, for example, competition for posts in geriatrics has
increased substantially in recent years. Therefore, the aim of the questions in this section was to examine the culture within the medical profession at the time consultants in the sample were training in order to put their experiences into context.

Section H - Medical Achievement

Finally, section H included questions about medical achievement, relating to the consultant’s attitude towards their achievement in their medical career, career aspirations for the future, reflections on their career and any influences on their career which had not been discussed. The aim of the questions in this section was to encourage consultants to be reflective about the effect their medical career had on their life. Questions about future career aspirations aimed to identify whether consultants considered the consultant grade to be the final stage in their medical career, and any future aspirations to be involved in national or regional committees, gain a merit award, develop their research interests or to be involved in management work.

4.8. Sampling

Demographic information about the consultants working in NHS hospitals in the South Thames Health Region was taken from the nominal roll (Advisory Committee on Distinction Awards, 1994/5). The nominal roll contains a list of consultants working in National Health Service hospitals in England and Wales which is produced
annually by the Department of Health. The nominal roll includes the following details about consultants; name, place of work, sex, year of birth, and year of first substantive consultant appointment in the NHS. The nominal roll is held at South Thames Regional Health Authority and is confidential. Permission for access to the nominal roll was obtained from the Regional Director of Public Health and the Medical Manpower Unit at South Thames Regional Health Authority. The nominal roll used in this study was produced in January 1995, which was the most up to date list available when the sample was selected in March 1995.

4.8.1. Grouping of the Hospital Medical Specialties

In order to examine variation across the hospital specialities, the specialities were grouped into six distinct groupings; these were diagnostic specialities, medical specialities, surgical specialities, psychiatry specialities, obstetrics and gynaecology and anaesthetics. I obtained advice from two doctors at St. George’s Hospital Medical School to develop criteria for selection of the groups. The selection of these groups was based on (i) the type of work carried out in these specialities; (ii) the hours worked (whether there is opportunity for sessional work, nine to five work or long working hours required in the hospital) and (iii) the amount of on call work required. Based on these criteria the groups were distinct from each other, however obstetrics and gynaecology and anaesthetics did not fit into the groupings and were therefore categorised as two separate speciality groups.
Group 1 - Diagnostic Specialities included radiology, radiotherapy*, nuclear medicine, histopathology, medical microbiology, immunopathology, virology, neuropathology, chemical pathology.

(i) Type of work is diagnostic laboratory services with no continuing responsibility for patients

(ii) Regular hours (9-5)

(iii) Little emergency on call commitment relative to other specialities

* The type of work undertaken in Radiotherapy is similar to the medical speciality group, however it has been categorised into the diagnostic speciality group because the hours worked and the amount of on call work required is similar to the diagnostic speciality group.

Group 2 - Medical Specialities included paediatrics, geriatric medicine, general medicine, dermatology, genito-urinary medicine, neurology, rheumatology, palliative medicine, audiological medicine, infectious diseases, thoracic medicine, cardiology, oncology and haematology.

(i) Involves inpatient, outpatient and emergency work

(ii) Long working hours but less than surgical specialities or obstetrics and gynaecology

(iii) Varying on call commitment, dependent on speciality and number of consultants in hospital. e.g. In dermatology, consultants are unlikely to be called into hospital but in general medicine, there is greater likelihood of emergency on call, which will vary according to the number of other general medicine consultants to share the on call rota.
**Group 3 - Surgical Specialities** included general surgery, cardio thoracic surgery, otolaryngology, neurosurgery, ophthalmology, paediatric surgery, plastic surgery, trauma and orthopaedic surgery, accident and emergency*, ENT and urology.

(i) Type of work involves hands on, practical work, with both routine and unpredictable emergency work

(ii) Long working hours

(iii) High on call commitment requiring emergency work in the hospital

*Accident and Emergency has more predictable on call work

**Group 4 - Psychiatry Specialities** included mental illness, mental handicap, old age psychiatry, child and adolescent psychiatry, psychotherapy and forensic psychiatry.

(i) Working as part of a multi-disciplinary team, with outpatient, inpatient and community work

(ii) Long working hours comparable to medical specialities

(iii) Variable on call commitment mainly provided over the telephone

**Group 5 - Obstetrics and Gynaecology**

(i) Type of work involves hands on practical work with routine and unpredictable emergency work

(ii) Long working hours

(iii) High levels of on call commitment requiring emergency work in the hospital
**4.8.2. Choice of Sampling Method**

A stratified sampling method was chosen to increase the precision of the sample. Bryman and Cramer (1995) describe the benefits of using a stratified sample, in comparison to other methods of sampling.

"The advantage of stratified sampling is that it offers the possibility of greater accuracy, by ensuring that the groups that are created by a stratifying criterion are represented in the same proportions as in the population" (Bryman and Cramer, 1995, p.102)

The aim was to achieve roughly equal numbers of male and female consultants in each speciality group in order to increase the opportunity to make comparisons between male and female consultants. A disproportionate sample was taken because there was variation amongst the number of male and female consultants in the various speciality groups. The numbers of female consultants in the surgical specialities (19) and obstetrics and gynaecology group (11) were significantly lower than in other speciality groups (Table 4.2). There were also significantly higher numbers of male consultants in the medical and surgical specialties than in other speciality groups. A uniform
sampling fraction was not used for the following reasons; a) to ensure accurate representation of male and female consultants in each speciality group; b) to ensure there were sufficient numbers of female consultants in the surgical and obstetrics and gynaecology groups for analysis. Analysis of data relating to female consultant surgeons and female consultant obstetrician and gynaecologists was particularly important for the overall aim of the study. If a uniform sampling fraction had been used, this group of female consultants would only represent a tiny number within the larger sample and comparisons between male and female consultants would be less reliable.

4.8.3. Sample Selection

The nominal roll includes consultants across all age groups. Before sampling took place, a new list was created, which only contained consultants who were aged forty to fifty years (i.e. born between 1945 and 1955 inclusive). The consultants in this new list were divided into two strata, by speciality group and gender.

A sampling fraction of 1 in 2 females and 1 in 6 males was used for the diagnostic speciality, medical speciality, psychiatry speciality and anaesthetics groups. For the surgical speciality group all women were selected and a sampling fraction of 1 in 9 males was used. For the obstetrics and gynaecology group, all females were selected and a 1 in 6 sample was taken for the males (Table 4.2). A random start of 3 was used. This produced a final sample of 286 consultants (Table 4.3). The final sample of consultants were evenly distributed across the South Thames Region, apart from a
slightly higher number of consultants in the South East London area (Table 4.3).

### Table 4.2. Sampling method

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Number of Consultants in South Thames Region (Born between 1945 and 1955)</th>
<th>Sampling Fraction</th>
<th>Number Selected in Final Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>116 64</td>
<td>1/6 1/2</td>
<td>19 32</td>
</tr>
<tr>
<td>Medical</td>
<td>260 93</td>
<td>1/6 1/2</td>
<td>45 46</td>
</tr>
<tr>
<td>Surgical</td>
<td>221 19</td>
<td>1/9 All</td>
<td>27 19</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>114 49</td>
<td>1/6 1/2</td>
<td>20 24</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>52 11</td>
<td>1/6 All</td>
<td>8 11</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>119 31</td>
<td>1/6 1/2</td>
<td>20 15</td>
</tr>
<tr>
<td>Total</td>
<td>882 267</td>
<td></td>
<td>139 147</td>
</tr>
</tbody>
</table>

### Table 4.3. Distribution of consultants in the study sample across South Thames Health Region

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Total No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sussex</td>
<td>49</td>
<td>(17)</td>
</tr>
<tr>
<td>Kent</td>
<td>50</td>
<td>(17)</td>
</tr>
<tr>
<td>Surrey</td>
<td>42</td>
<td>(15)</td>
</tr>
<tr>
<td>South East London</td>
<td>78</td>
<td>(27)</td>
</tr>
<tr>
<td>South West London</td>
<td>67</td>
<td>(23)</td>
</tr>
<tr>
<td>Total</td>
<td>286</td>
<td>(100)</td>
</tr>
</tbody>
</table>
4.9. **Pilot Study**

Pilot interviews were undertaken in January 1995, to test the semi structured interview schedule. Twenty consultants were selected for the pilot interviews from the South Thames Region 1994/5 nominal roll. The consultants selected included male and female consultants across all medical speciality groups, apart from women consultant surgeons and obstetricians and gynaecologists. I wanted to include all women consultant surgeons and obstetricians and gynaecologists in the main part of the study because there were small numbers of women consultants in these specialities in South Thames Region. Three additional pilot interviews were undertaken with female consultants in the surgical and obstetrics and gynaecology speciality groups, who were working at the John Radcliffe Hospital in Oxford.

The John Radcliffe Hospital was chosen because of personal contact with the Director of Public Health and Health Policy at Oxford District Health Authority. She contacted the personnel department who nominated the names of three consultants who I then contacted for an interview. The total number of pilot interviews undertaken was nineteen, including sixteen out of the twenty consultants selected from the South Thames Region and three women consultants in the Oxfordshire Health Region. Four consultants were not interviewed for a number of reasons; (i) one consultant did not want to be involved in the research, (ii) one consultant was on maternity leave, and was included in the sampling frame for the main part of the research, (iii) one consultant was not in the age group and (iv) one consultant could not be traced. The latter two responses emphasised the importance of ensuring that the sampling frame
was the most up to date list available.

The pilot interviews were tape-recorded and took place at the consultant's place of work. The average length of time for the interview was one hour. Responses to the structured questions were filled in during the interview and the open ended questions in each pilot interview were transcribed after the interview. A number of changes were made to the interview schedule as a result of the pilot interviews, in particular the pilot interviews highlighted the need to include a more detailed analysis of the domestic division of labour.

4.10. Recruitment and Training of Interviewers

I planned to undertake the majority of the interviews, however a total sample of 286 was too large for me to undertake solely on my own, therefore four women interviewers were recruited to undertake interviews in the Surrey, Sussex, Kent and South East London areas of the South Thames Health Region. I undertook a total of 72 interviews which included 47 interviews in the South West London area and 25 interviews in Sussex, Kent and South East London.

The four woman interviewers were recruited through personal contacts. Three interviewers had completed or were in the process of completing the MSc in Social Research course at the University of Surrey and all four interviewers had previous interviewing experience. Two of the interviewers undertook a two day interviewer training programme during January 1995. The other two interviewers undertook a one
day individual training session because they were recruited at later dates. The training programme, which I organised and conducted, was held at the University of Surrey and involved background information about the research, practical issues, such as, contacting consultants and arranging interviews, practical sessions using the interview schedule, recording the information and observation of a role play interview with a consultant in Public Health Medicine. After the training days, I accompanied the interviewers on a pilot interview with a hospital consultant from the sample. After this interview we discussed any issues that had arisen during the interview and once this interview had been successfully completed the interviewers continued with their allotted interviews independently. During this period I was in regular contact with the interviewers to monitor the quality and progress of their interviews.

4.11. Data Collection

Each interviewer was given a list of doctors to contact in their area of residence. The interviews with consultants took place between February and August 1995. I sent a letter to each doctor in the sample informing them of the study and asking if they would be willing to be interviewed (Appendix 3). The letter stated the aim, purpose and anticipated outcome of the research, the age and characteristics of the sampled consultants, the estimated time the interview would take and affirmed confidentiality of the information given in the interview. For the Surrey, Sussex, Kent and South East London areas, the letter also stated the name of the relevant interviewer who would be undertaking the interview and that she would be contacting them in the near future.
Five to six days after the letter had been sent the interviewer contacted the consultant or their secretary to arrange an appropriate date and time for the interview. Invariably, arranging an appointment took more than one telephone call. A number of appointments for interview were arranged several weeks after the telephone call. In these instances, a letter was sent confirming the date and time of the interview. In some cases, up to eight telephone calls were required, and second copies of the original letter were sent or faxed before a suitable interview date could be arranged.

When a date had been arranged the consultant was asked if he or she could forward a copy of their work history or curriculum vitae to the interviewer. It was stressed that this should be whatever was available since I did not want to impose any extra work onto the consultants. Each consultant was told that the reason for sending their curriculum vitae was to enable the interview to be kept as brief and as constructive as possible.

4.11.1. Purpose of the Curriculum Vitae

Before each interview the consultant’s curriculum vitae was used to fill in the first part of the work and life history grid (Appendix 4). Details were used from the curriculum vitae to fill in details relating to medical grade, speciality and place of work for each year, from the beginning of medical school to the time of the interview. The curriculum vitae was also used to provide the interviewer with preliminary information prior to the interview. It was useful to have details relating to marital status, children, periods working abroad and research publications prior to the interview which could be discussed in greater detail during the interview.
To maximise response, the postal address for the consultant’s curriculum vitae was St. George’s Hospital Medical School. A copy of the curriculum vitae was forwarded to the interviewer prior to the interview. In some cases consultants sent their curriculum vitae direct to the interviewer’s home address. A number of consultants did not send their curriculum vitae prior to the interview. In these cases, consultants either had a copy of their work history when we met for the interview, or they were able to provide details which were written on to the work life history grid during the interview.

4.11.2. Interviews

The majority of interviews took place at the consultant’s place of work and the remainder took place at their home. The interviews lasted between forty five minutes and two and a half hours, with an average length of one hour. For those interviews which lasted over one hour, we asked the consultant permission to continue with the interview. In all cases they were happy to continue with the interview. Once the interview began, we found that many consultants were happy to talk very frankly, honestly and at great length about their experiences and did not mind extending the time of the interview. For many consultants it was an opportunity to be reflective about their medical careers to date and some of the consultants mentioned that it had been very therapeutic to talk about their experiences. As a result, we were given the impression that the extra time they had given for the interview was considered to be valuable and worthwhile.
In the majority of interviews, the consultants talked in detail about their experiences. Among some consultants it was the first time they had given any detailed thought to their career and the effect it had on their life. Consequently, some of the interviews were very emotional, with a few consultants expressing anger, frustration and sadness. However, many of the consultants were very happy with their career and family life and this was expressed very positively during the interviews. My own experience during the interviews was that for a period of an hour I became completely engrossed in the consultant’s answers to my questions and when this conversation was mixed with sadness, regret and anger, the interview was mentally tiring. For this reason, I tried to arrange only one interview appointment per day, although this was not always possible when I was travelling to specific parts of the region, where there were several sample consultants working at the same hospital. The interviews were also reflective in nature and demonstrated the advantage of interviewing doctors who had reached the top of their careers and were in the middle stage of their life course. Overall, the quality of the data collected during the interviews was good and rich in context.

The effect that an interviewer can have on the respondent’s statements has been documented in previous research (Katz, 1942; Hyman, 1954; Babbie, 1973). All of the interviewers were female and had a non medical background. The gender of the interviewers may have benefited the quality of the data collected. Amongst female consultants, a female interviewer may have helped in developing rapport, since the topics being discussed were related to women’s employment. Amongst male consultants, the interviewers were possibly perceived as non threatening, which benefited rapport and also the quality of the information collected.
A non medical background may have influenced the interview data. In some cases, different professional backgrounds between the interviewer and respondent may have reduced rapport. However being perceived as a social scientist and thus quite separate from Medicine, increased our neutrality and we were less likely to be seen as threatening, which overall benefited the quality of the interviews. Although I had not undergone any medical training, I found it beneficial to the interviews to have worked within the medical field. I had a basic understanding about the structures and environment within Medicine, which gave me a good foundation during the interviews.

We needed to adapt the pace of the questioning during the interviews according to the consultant being interviewed. Personality types vary quite considerably across the medical specialties and we needed to use our skills to maintain control of the interview on several occasions. The majority of interviews took place at the arranged time, with few interruptions. However, consultants work within busy time schedules, which include operation lists and clinics which can invariably run beyond schedule. This type of work schedule affected how and when we were able to undertake some of the interviews. In some cases, the time available for the interview was considerably shorter because a clinic or an operating list had run over time. In these cases, data on work history was not collected, because it was the most time consuming part of the interview. Some interviews were interrupted while the consultant attended to an emergency. In these cases, the interviewer waited and continued the interview at a later time in the day. Some interviews were undertaken at the consultant’s home because they were on maternity leave, which created interruptions to the interview. Interruptions to the interview meant that both the flow of conversation and rapport
were affected which had to be overcome.

The majority of interviews took place in the consultant’s workplace. A quiet, private place to undertake the interview was important to maximise the quality of the consultant’s answers. However, this was not always possible. Some of the interviews took place with a secretary in the same room, some took place in a general common room, with other members of staff entering and leaving the room. This environment had two effects, (i) it increased the amount of background noise on the tape recordings and therefore made transcription harder and (ii) it may have had an effect on the consultants answers, in terms of the depth and fullness of their response. Myself and the other interviewers, therefore had to be flexible to the interview situation and aim to get the best quality information within these constraints.

4.11.3. Recording the Information

Information collected during the interviews was recorded in two main ways; (i) manually onto the pre-coded interview schedule (Appendix 2) during the interview and (ii) by tape recording. The interviews were tape recorded for two main reasons. Firstly to provide a test of interviewer reliability and secondly to enable the open ended questions to be transcribed and analysed using qualitative data analysis methods. Using tape recorders to record the interviews was also important in increasing the free flow of the conversation and helped in developing rapport. Recording the open ended questions on to the interview schedule during the interview would have been time consuming and would have hindered the flow of the conversation. Using tape
recordings increased the rapport between the interviewer and consultant because it was possible to maintain eye contact and the interview appeared more like a guided conversation. Tape recording of the interviews was also important in enabling detailed information to be collected and also enabled verbatim quotes to be used as illustration in the text. Few consultants objected to the tape recording, and in the majority of cases, the presence of a tape recorder did not appear to affect the consultant’s response.

4.11.4. Coding and Managing the Data

The majority of the questions on the interview schedule were precoded, therefore the appropriate code was entered on to the schedule during the interview. However, the coding of some questions was more complex, for example, the domestic division of labour. In these cases, the codes were entered onto the interview schedule after the interview was complete, by listening to the tape recording. Although the majority of questions were precoded, several consultants gave answers which did not fit into the categories on the interview schedule. Additional codes were created before the data was entered into the SPSS data file. Information relating to employment status, occupation and employment status of partner, timing of birth of children and place of work were completed onto the work and life history grid during the interview.

Coding of the work and life history grids was undertaken after data collection was complete. A separate data file was established for the work and life history grids and the following variables were entered; identification number, sex, period (ordered
numerically for each year from medical school until 1995), medical grade, speciality, employment status, place of work, marital status, birth of child, partner's occupation, partner's employment status. For each consultant, details were entered for every year from the final year of medical school until 1995. In some cases, up to twenty nine rows of information were entered for each consultant.

Data entry files were established in Statistical Package for the Social Sciences (SPSS) and the data were entered from the interview schedules into the SPSS file. Once entered the data were checked against the original interview schedule and by running frequencies to identify any incorrect values within the data. The answers to the open ended questions were transcribed in preparation for analysis. All data entry, coding and transcription was undertaken by myself.

4.12 Validity and Reliability

4.12.1. Validity

Two types of data collection, in depth interviews, during the pilot work, and semi structured interviews, during the main study, were used to increased the validity of the findings. Shipman (1981) suggests that;

"asking questions to get valid answers is a skilled and sensitive job requiring knowledge of the environment in which the interview is to be conducted" (Shipman, 1981, p.89).
Using qualitative interviews during the early stages of the study provided an insight into the environment and context in which the study was to be undertaken. They also provided information about the key issues and terminology that were used by doctors and this information was used to improve the question wording in the interview schedule for the main part of the study.

All the interviews were tape recorded which increased the validity of the data by ensuring an accurate recording of the conversations. Recording of the interviews facilitated probing during the open ended questions. Probing of the open ended questions enabled a more in depth discussion of the issues being studied, which benefited the validity of the findings.

Ensuring validity of the findings involves a certain amount of control over the interview. One means of control is the context in which the interview takes place. The majority of interviews took place in the consultant’s office, therefore creating an environment where confidentiality was increased. This environment hopefully encouraged the consultants to speak more openly than if the interview had taken place in a less private environment.

This is a retrospective study which means that some aspects of the information collected were based on memory, and naturally, answers may be biased by changed perceptions over time. The curriculum vitae was important in this respect, by providing accurate information on the timing of career changes and family events for each consultant.
4.12.2. Reliability

"A reliable measurement is one where we obtain the same result on repeated occasions" (De Vaus, 1993, p.54.).

Reliability of data can be reduced when there is more than one interviewer. Due to the large numbers of doctors in the sample, there was a need to employ four interviewers. It is acknowledged therefore that reliability could be jeopardised. A number of methods were used to increase the reliability of the findings. Firstly, the interviewers underwent training to ensure they asked the questions on the interview schedule in the way they were worded and the order in which they were written. With the open ended questions there was a need to use a number of probes. Interviewers were trained on the use of neutral probing techniques.

Secondly, to ensure interviewer reliability, I listened to eighty tape recordings of the interviews undertaken by the four interviewers, which were selected at different stages of the interview process and compared the tape recorded information with the information recorded on the interview schedule. I also listened to the first ten tape recorded interviews for each interviewer, to check the quality of the interviews. Any bias or problems were discussed with the interviewer in the early stages of data collection. Over probing and under probing of the open ended questions were two problems which arose at this stage and after discussion with the interviewers these problems were rectified. Thirdly, at the coding and editing data stage of the study, I checked all the interview schedules, to ensure they were coded appropriately. I solely
undertook this final stage of coding, therefore reducing the likelihood of bias created by error from more than one person coding the data.

A further problem relating to reliability is that respondents may give different answers to questions on different occasions. In my study, consultants may have different attitudes towards the relationship between their career and family life, dependent on current circumstances. For example, reflections on the effect that their medical career has had on their personal life may be particularly negative, if the consultant is feeling demoralised and dissatisfied with his or her job on the day of the interview.

4.13. Methods of Analysis

The data analysis was based around the four research questions. Variation between gender and medical speciality group provided an overall framework in which to undertake the analysis. In particular, the analysis focused on variation between (i) female consultants and male consultants in the same speciality and (ii) between female consultants in different specialities. A combination of quantitative and qualitative data analysis methods were used.

4.13.1. Quantitative Data Analysis Methods

Frequencies were used initially to describe the data. Bivariate analysis methods were used. A 0.05 probability level was used as a cut off point to report results which were statistically significant. The information in the work and life history grids was
graphically presented using the graphics option in SPSS.

Weighting was not used in the analysis of the data on hospital consultants. A disproportionate stratified sample was taken and therefore the proportions of women and men in the sample are different from that in the population of all hospital consultants. The aim of my thesis was to compare gender differences in the sample of consultants and differences between men and women in different medical speciality groups, therefore it is not appropriate to reweight the sample data by gender. Inferences will not be made from my findings to the population of all consultants. When reference is made to all male or all female consultants, this analysis should be interpreted in the context that there is a differential selection of male and female consultants between specialities. For example, all female consultant surgeons and obstetricians and gynaecologists are included in the sample but only 1 in 2 female consultants in the other specialities are included. Therefore, inferences to all female consultants in my analysis does not refer to all female consultants in the population.

4.13.2. Qualitative Data Analysis Methods

The answers to the open ended questions in the interview schedule were analysed using the 'Framework' qualitative data analysis method which is a technique developed by the Social and Community Planning Research Unit (SCPR) (Ritchie and Spencer, 1994) for applied policy research. This type of qualitative data analysis method was chosen because it has been designed to "facilitate systematic analysis" (Ritchie and Spencer, 1994, p.176). It was considered suitable for analysing qualitative
text produced from open ended questions in a semi structured interview.

The first stage of my analysis involved reading the interview transcripts to familiarise myself with the interview data and to identify any initial themes prevalent in the data. After which a thematic framework was developed for male and female consultants in the following topic areas; personal and social effects of the inter-relationship between professional and family life, effect on relationships, effect on family life, disruption to family life, benefits to family life, organisational influences, barriers to career development, benefits to career development, level of support, other’s attitude to motherhood, children and part time work.

Once the framework was finalised, I undertook the process of indexing the transcripts by putting the codes from the thematic framework directly onto the margins of the transcript. The final stages of the analysis involved charting the data. In this stage, charts were developed for each key theme identified in the data (Appendix 5). The charts were designed for a thematic approach to analysis. The charts were devised according to each key theme and on each chart numerically ordered identification codes were used to identify cases. Short notes detailing each consultant’s response were written onto the charts. This method of data analysis allows analysis between and across cases. In the final stages of the analysis, the charts were used to make associations between different parts of the data in order to help to develop theory.
4.14. **Response Rate of Consultants**

A total of 202 NHS hospital consultants were included in the final sample, giving a response rate of 73 per cent (Table 4.4), which given the amount of time required to undertake the interview, was a high response rate. Discussion with consultants regarding their willingness to be interviewed suggests that the research issues being explored were of particular concern to them, and the fact that the study was being undertaken under the auspices of a medical school. Eleven consultants in the original sample of 286 were considered ineligible. These consultants were ineligible for three reasons; (i) they were not aged between 40 and 50 years, (ii) they were no longer working in South Thames Region, (ii) they had left Hospital Medicine. One female consultant surgeon was aged fifty one, however she was included in the final sample, because there were few female surgeons working in the South Thames Region. Experiences of professional and personal lives of female surgeons are likely to be important to this study.

Overall, there was a higher response rate from female consultants (82%) than male consultants (64%). Both male and female consultants were represented in all six speciality groups. However, male consultants were less representative in the surgical and diagnostic specialities (response rates of 58% and 53% respectively) and female consultants were less representative in anaesthetics (67%) (Table 4.4).
Table 4.4. Response rate of consultants by speciality group

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Number Eligible in Sample</th>
<th>Response</th>
<th>Total Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No.</td>
<td>Female No.</td>
<td>Male No.</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>19</td>
<td>31</td>
<td>10 (53)</td>
</tr>
<tr>
<td>Medical</td>
<td>43</td>
<td>43</td>
<td>28 (65)</td>
</tr>
<tr>
<td>Surgical</td>
<td>26</td>
<td>18</td>
<td>15 (58)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>19</td>
<td>23</td>
<td>13 (68)</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>8</td>
<td>11</td>
<td>6 (75)</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>19</td>
<td>15</td>
<td>14 (74)</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>141</td>
<td>86 (64)</td>
</tr>
</tbody>
</table>
CHAPTER 5
Profile of the Consultants in the Sample

This chapter provides an introduction to the analysis of data on consultants in subsequent chapters, by describing the characteristics of the hospital consultants in the sample. In particular, it will provide descriptive information about the professional life and the family life of NHS hospital consultants.

5.1. Age and Sex

There were slightly more female consultants than male consultants in the sample interviewed (57% and 43% respectively). Female consultant anaesthetists and male consultants in the surgical and diagnostic specialities were under represented in the sample as discussed in chapter four (Table 4.4).

Despite the fact that a representative sample of consultants age forty to fifty years was undertaken, female consultants were significantly younger than the male consultants (P<0.01) (Table 5.1). The mean age for female consultants was 44.2 years and the mean age for male consultants was 46.1 years. Within the speciality groups, female consultants were one to two years younger than male consultants, apart from obstetrics and gynaecology where male consultants were four years older than their female colleagues (Table 5.2).
Table 5.1. Age and sex of consultants

<table>
<thead>
<tr>
<th>Age</th>
<th>Male Consultants No.</th>
<th>Female Consultants No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>40-45 years</td>
<td>42 (49)</td>
<td>78 (67)</td>
<td>120 (59)</td>
</tr>
<tr>
<td>46-51 years</td>
<td>44 (51)</td>
<td>38 (33)</td>
<td>82 (41)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

Chi-square=6.93  P<0.01

Table 5.2. Mean age of consultants by speciality group

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Male Consultants (mean age in years)</th>
<th>Female Consultants (mean age in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>45.7</td>
<td>43.9</td>
</tr>
<tr>
<td>Medical</td>
<td>46.7</td>
<td>45.1</td>
</tr>
<tr>
<td>Surgical</td>
<td>45.7</td>
<td>43.3</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>45.2</td>
<td>43.7</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>47.5</td>
<td>43.7</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>45.8</td>
<td>44.6</td>
</tr>
<tr>
<td>All</td>
<td>46.1</td>
<td>44.2</td>
</tr>
</tbody>
</table>

5.2. Professional Life

All areas of the South Thames Health Region were represented in the sample interviewed, with a slightly higher proportion of female consultants working in the South London area (Table 5.3).
Table 5.3. Distribution of consultants across the South Thames Health Region

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>South London</td>
<td>29 (34)</td>
<td>49 (42)</td>
<td>78 (39)</td>
</tr>
<tr>
<td>Surrey</td>
<td>15 (17)</td>
<td>27 (23)</td>
<td>42 (21)</td>
</tr>
<tr>
<td>Sussex</td>
<td>22 (26)</td>
<td>15 (13)</td>
<td>37 (18)</td>
</tr>
<tr>
<td>Kent</td>
<td>20 (23)</td>
<td>25 (22)</td>
<td>45 (22)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

The majority of consultants were working full time which includes consultants who were working on a maximum part time basis and involved in private practice work. However, 19 per cent of female consultants and no male consultants were working part time (Table 5.4).

Table 5.4. Current employment status of consultants

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time employment*</td>
<td>86 (100)</td>
<td>94 (81)</td>
<td>180 (89)</td>
</tr>
<tr>
<td>Part time employment</td>
<td>0 (0)</td>
<td>22 (19)</td>
<td>22 (11)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

* includes maximum part time employment  
Chi-square=17.37  P<0.001

5.2.1 Age Consultant Post Was Achieved

The majority of consultants achieved their first substantive consultant post in an NHS hospital between the age of 34 and 37 years. The mean age for achieving consultant
status for men was 37.3 years and the mean age for women was 36.3 years. Little variation existed between male and female consultants in the same speciality. Overall, female consultants achieved consultant grade at least one year earlier than their male colleagues in the same speciality, apart from female anaesthetists who achieved consultant grade one year later than their male colleagues (Table 5.5).

Table 5.5. Mean age achieved first substantive consultant post according to speciality group

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Male Consultants (mean age in years)</th>
<th>Female Consultants (mean age in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>37.0</td>
<td>34.4</td>
</tr>
<tr>
<td>Medical</td>
<td>37.1</td>
<td>37.2</td>
</tr>
<tr>
<td>Surgical</td>
<td>37.2</td>
<td>36.6</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>38.0</td>
<td>37.2</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>40.7</td>
<td>37.0</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>35.7</td>
<td>36.2</td>
</tr>
<tr>
<td>All</td>
<td>37.3</td>
<td>36.3</td>
</tr>
</tbody>
</table>

5.2.2. Years in Consultant Post

Male consultants had been in post slightly longer than female consultants, which reflects the higher proportion of older male consultants in this sample (Table 5.6). The mean years that male consultants had been in post was 8.5 years compared with the mean years for female consultants which was 7.8 years. Two thirds of the consultants had been in post for at least five years (Table 5.6) and have therefore experienced the introduction of general management into the NHS in 1983 and changes to working practices following introduction of the NHS reforms in 1991. Consequently the
majority of consultants in this sample have undergone considerable change in their
daily working life.

Table 5.6. Number of years in consultant post

<table>
<thead>
<tr>
<th>Number of Years as a Consultant</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Four years and under</td>
<td>22</td>
<td>(25)</td>
<td>29</td>
</tr>
<tr>
<td>Five to twelve years</td>
<td>48</td>
<td>(56)</td>
<td>68</td>
</tr>
<tr>
<td>Thirteen years and over</td>
<td>16</td>
<td>(19)</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>(100)</td>
<td>116</td>
</tr>
</tbody>
</table>

5.2.3. Type of Work

There are two types of hospital consultants, teaching hospital consultants and district
general hospital consultants. The type of work undertaken within these two types of
hospital is quite different. Teaching hospital consultants are involved in research,
teaching and academic work, as well as clinical work. District general hospital
consultants are primarily involved in clinical work and service provision.

There were forty six acute hospitals in the South Thames Region at the time the
interviews took place. Forty three were district general hospitals and three were
undergraduate teaching hospitals. The teaching hospitals were; St. George’s Hospital,
Guy’s Hospital and St. Thomas’s Hospital (UMDS) and King’s College Hospital.
Forty four (22%) of the hospital consultants interviewed were consultants at London
teaching hospitals. There were equal proportions of men and women represented at
London teaching hospitals (22% and 22% respectively) and district general hospitals (78% and 78% respectively).

5.2.4. Distinction Awards

Data relating to distinction awards was collated from the 1994/95 nominal roll (which was also used for the sampling frame for this study). This shows that in 1994/95, 19 per cent of interviewed consultants held a distinction award (sometimes called a merit award). Over twice as many men than women held distinction awards (27% compared with 13%). Further gender differences existed regarding the grade of distinction awarded, which can range from A plus to C. Thirty five per cent of male consultants compared to 26 per cent of female consultants had a grade B award or above (Table 5.7).

Table 5.7. Holders of a distinction award by grade awarded as at January 1995

<table>
<thead>
<tr>
<th>Grade of Distinction Award</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>A plus</td>
<td>0</td>
<td>(0)</td>
<td>0</td>
</tr>
<tr>
<td>A</td>
<td>1</td>
<td>(4)</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>7</td>
<td>(30)</td>
<td>3</td>
</tr>
<tr>
<td>C</td>
<td>15</td>
<td>(65)</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>(100)</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi-square=0.55 Not Significant

Overall, older consultants (aged 46-51 years) were more likely to receive a distinction award. However, men aged 40 to 45 years were more likely to receive an award than
women in the same age group (12% compared to 6%) (Table 5.8).

Table 5.8. Percentage of consultants with a distinction award by age as at January 1995

<table>
<thead>
<tr>
<th>Age</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Significance</td>
</tr>
<tr>
<td>40-45 years</td>
<td>5 (12)</td>
<td>5 (6)</td>
<td>10 (8) NS</td>
</tr>
<tr>
<td>46-51 years</td>
<td>18 (41)</td>
<td>10 (26)</td>
<td>28 (34) NS</td>
</tr>
<tr>
<td>All</td>
<td>23 (27)</td>
<td>15 (13)</td>
<td>38 (19) P&lt;0.01</td>
</tr>
<tr>
<td>Numbers in</td>
<td>(N=86)</td>
<td>(N=116)</td>
<td>(N=202)</td>
</tr>
<tr>
<td>whole sample</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Consultants at London teaching hospitals were more likely to have a distinction award than consultants working in other types of hospital. More male than female London teaching hospital consultants had a distinction award (47% compared to 19%) (Table 5.9).

Table 5.9. Percentage of consultants with a distinction award by type of hospital as at January 1995

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Significance</td>
</tr>
<tr>
<td>London Teaching</td>
<td>9 (47)</td>
<td>6 (19)</td>
<td>15 (34) P&lt;0.05</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non London</td>
<td>14 (21)</td>
<td>9 (10)</td>
<td>23 (14) NS</td>
</tr>
<tr>
<td>Teaching Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23 (27)</td>
<td>15 (13)</td>
<td>38 (19) P&lt;0.01</td>
</tr>
<tr>
<td>(N=86)</td>
<td>(N=116)</td>
<td>(N=202)</td>
<td></td>
</tr>
</tbody>
</table>
The highest likelihood of receiving a distinction award was by consultants in the medical speciality and obstetrics and gynaecology speciality groups and the smallest proportion were held by consultants in anaesthetics (Table 5.10). Nearly half of male consultants in the medical speciality group, compared with under a tenth of female consultants in the same speciality, held a distinction award in 1994/95 (Table 5.10).

Table 5.10. Percentage of consultants who have a distinction award by medical speciality group as at January 1995

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Male Consultants No.</th>
<th>Male Consultants %</th>
<th>Female Consultants No.</th>
<th>Female Consultants %</th>
<th>Total No.</th>
<th>Total % Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>2 (20)</td>
<td></td>
<td>4 (14)</td>
<td></td>
<td>6 (15)</td>
<td>NS</td>
</tr>
<tr>
<td>Medical</td>
<td>12 (43)</td>
<td></td>
<td>2 (6)</td>
<td></td>
<td>14 (24)</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Surgical</td>
<td>3 (20)</td>
<td></td>
<td>2 (12)</td>
<td></td>
<td>5 (16)</td>
<td>NS</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2 (15)</td>
<td></td>
<td>4 (20)</td>
<td></td>
<td>6 (18)</td>
<td>NS</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>2 (33)</td>
<td></td>
<td>2 (22)</td>
<td></td>
<td>4 (27)</td>
<td>NS</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>2 (14)</td>
<td></td>
<td>1 (10)</td>
<td></td>
<td>3 (13)</td>
<td>NS</td>
</tr>
<tr>
<td>All</td>
<td>23 (27)</td>
<td></td>
<td>15 (13)</td>
<td></td>
<td>38 (19)</td>
<td>P&lt;0.01</td>
</tr>
</tbody>
</table>

The length of time in consultant grade did not seem to have a significant impact on receiving a distinction award for male consultants but it did for female consultants. Analysis of gender differences in holders of distinction awards by the length of time in consultant post, indicates that more men than women who had been in post for ten years or under were holders of a distinction award (Table 5.11).
Table 5.11. Percentage of consultants who have a distinction award by number of years in consultant post as at January 1995

<table>
<thead>
<tr>
<th>Length of Time in Consultant Post</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. % Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years and under</td>
<td>3 (10)</td>
<td>0 (0)</td>
<td>3 (4) P&lt;0.05</td>
</tr>
<tr>
<td>6-10 years</td>
<td>15 (32)</td>
<td>5 (9)</td>
<td>19 (19) P&lt;0.01</td>
</tr>
<tr>
<td>11-15 years</td>
<td>5 (50)</td>
<td>10 (45)</td>
<td>15 (47) NS</td>
</tr>
<tr>
<td>All</td>
<td>23 (27)</td>
<td>15 (13)</td>
<td>38 (19) P&lt;0.01</td>
</tr>
</tbody>
</table>

In summary, male consultants were more likely than female consultants to have a distinction award, after adjusting for age and number of years in post. Men were more likely than women to be awarded a higher level of distinction. Male consultants in the medical speciality group were most likely to have an award, and consultants in anaesthetics were least likely to have an award. Male teaching hospital consultants were more likely to have an award than female teaching hospital consultants.

5.2.5. Work Histories of Consultants

Data on the work history for each consultant was collected from the year he/she graduated from medical school to 1995 (see chapter four). The grades that consultants were working in during their medical career were classified into five categories; (i) General (General Professional Training); (ii) Higher (Higher Specialist Training); (iii) Career (Career Grade i.e. Consultant, Staff Grade, Associate Specialist); (iv) Academic (Research Fellow, Lecturer, Senior Lecturer, Professor) and (v) Other Medical (any grade not in Hospital Medicine, i.e. GP trainee, Senior Clinical Medical Officer).
Periods spent not working in Medicine were classified as "break" which refers to time spent unemployed, travelling or a break to care for children/relatives, or working in a job unrelated to Medicine. Figure 5.1 and Figure 5.2 show aggregate data relating to the career path for male and female consultants from the end of medical school (shown by 1 on the x axis) to 1995 (the 1995 point on the x axis varies for each individual consultant because of the variation in the number of years since completion of medical training). Due to the varying age range of consultants, information is available for more years amongst the older consultants, which explains the gradual slope after nineteen years post medical school.

The data shown in Figure 5.1 and Figure 5.2 therefore represents the number of doctors who were working in a particular grade at a particular point in time following graduation from medical school. For example 13 years after leaving medical school, 1 per cent of male consultants were in general professional training, 36 per cent of male consultants were in higher specialist training, 47 per cent were working in a career grade (the majority were consultants), 14 per cent were working in academic medical posts, and 1 per cent were working in a non hospital medical grade.

Comparing the career path of male and female consultants in this way shows that fewer female consultants (Figure 5.1) than male consultants (Figure 5.2) held academic posts during their medical career. Gaining access to research posts is closely tied to networks, in particular the old boy network, which may have disadvantaged women. These data suggest that the difference in the number of women holding academic posts in their career, may have reduced opportunity for women to
Figure 5.1. Work history from the end of medical school to 1995
Female Consultants

Each year from the end of medical school until 1995

Figure 5.2. Work history from the end of medical school to 1995
Male Consultants

Each year from the end of medical school until 1995
undertake research and write research papers, which are important factors in a teaching hospital career and also in attaining a distinction award.

5.3. **Family Life**

The majority of consultants were married (82%). A tenth were single and under a tenth were divorced or widowed. The majority of married or cohabiting consultants were in heterosexual relationships. Two male consultants and no women consultants had been in homosexual relationships in the past, but at the time of the interview they were not cohabiting. Women consultants were more likely to be single than male consultants (14 per cent compared with 5 per cent) (Table 5.12). In comparison to previous generations of female consultants, a greater proportion of women had combined a medical career and family life. Born during the post war years and graduating from medical school in the late 1960s and 1970s, the female consultants interviewed were training to be doctors at a time when increasing numbers of women were entering the labour market. Even within the surgical specialities, the majority of female consultants were married (Table 5.13).
Table 5.12. Marital status of consultants

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Male Consultants No.</th>
<th>Female Consultants No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Single</td>
<td>4 (5)</td>
<td>17 (14)</td>
<td>21 (10)</td>
</tr>
<tr>
<td>Married/Cohabited (Once)</td>
<td>66 (77)</td>
<td>79 (68)</td>
<td>145 (72)</td>
</tr>
<tr>
<td>Married/Cohabited (More than Once)</td>
<td>10 (12)</td>
<td>10 (9)</td>
<td>20 (10)</td>
</tr>
<tr>
<td>Divorced/Separated/Widowed</td>
<td>6 (7)</td>
<td>10 (9)</td>
<td>16 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

Chi-square=5.88  Not Significant

The majority of consultants were married during their training years and 14 per cent had married as students (Table 5.14). The mean age for first marriage for female consultants was 28 years and for male consultants the mean age was 29 years. National data for the United Kingdom shows that between the period 1971 to 1993 the average age at first marriage increased from 22.6 years to 26.2 years for women and from 24.6 years to 28.1 years for men (OPCS, 1990). Both male and female consultants married at a later age than the average age amongst the population of the United Kingdom. Female consultants were married at a later grade in their career than male consultants. Fifty four per cent of male consultants compared with 62 per cent of female consultants were married during or after higher specialist training (Table 5.14).
<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No.%</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Single</td>
<td>0 (0)</td>
<td>2 (7)</td>
<td>1 (3)</td>
<td>8 (26)</td>
<td>1 (7)</td>
<td>3 (18)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Married/Cohabiting</td>
<td>9 (90)</td>
<td>23 (79)</td>
<td>26 (93)</td>
<td>22 (71)</td>
<td>14 (93)</td>
<td>14 (82)</td>
<td>9 (69)</td>
</tr>
<tr>
<td>Divorced/Separated/Widowed</td>
<td>1 (10)</td>
<td>4 (14)</td>
<td>1 (3)</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (23)</td>
</tr>
<tr>
<td>Total</td>
<td>10 (100)</td>
<td>29 (100)</td>
<td>28 (100)</td>
<td>31 (100)</td>
<td>15 (100)</td>
<td>17 (100)</td>
<td>13 (100)</td>
</tr>
</tbody>
</table>
Table 5.14. Grade at first marriage for hospital consultants

<table>
<thead>
<tr>
<th>Grade at first marriage</th>
<th>Male Consultants No.</th>
<th>Female Consultants No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Medical School</td>
<td>10 (13)</td>
<td>13 (15)</td>
<td>23 (14)</td>
</tr>
<tr>
<td>General Professional Training</td>
<td>25 (33)</td>
<td>21 (24)</td>
<td>46 (28)</td>
</tr>
<tr>
<td>Higher Specialist Training</td>
<td>31 (41)</td>
<td>44 (49)</td>
<td>75 (45)</td>
</tr>
<tr>
<td>Consultant</td>
<td>10 (13)</td>
<td>11 (12)</td>
<td>21 (13)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>89 (100)</td>
<td>165 (100)</td>
</tr>
</tbody>
</table>

Chi-square = 2.02  Not Significant

5.3.1. Occupation and Employment Status of Partner

Differences were evident between male and female consultants in both the occupation and employment status of their partners. The majority (84%) of the partner’s of female consultants were working full time or were self employed, compared with over half (63%) of male consultant’s partners who were full time housewives or working part time (Table 5.15).
Table 5.15. Current employment status of consultant’s partner: married/cohabiting consultants

<table>
<thead>
<tr>
<th>Employment Status of Partner</th>
<th>Male Consultants No.</th>
<th>%</th>
<th>Female Consultants No.</th>
<th>%</th>
<th>Total No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time/Self Employed</td>
<td>24 (32)</td>
<td></td>
<td>75 (84)</td>
<td></td>
<td>99 (60)</td>
<td></td>
</tr>
<tr>
<td>Part Time</td>
<td>24 (32)</td>
<td></td>
<td>6 (7)</td>
<td></td>
<td>30 (18)</td>
<td></td>
</tr>
<tr>
<td>Unemployed/Student/Retired</td>
<td>4 (5)</td>
<td></td>
<td>6 (7)</td>
<td></td>
<td>10 (6)</td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>24 (32)</td>
<td></td>
<td>2 (2)</td>
<td></td>
<td>26 (16)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td></td>
<td>89 (100)</td>
<td></td>
<td>165 (100)</td>
<td></td>
</tr>
</tbody>
</table>

Chi-square = 60.24  P < 0.001

The current occupation for each consultant’s partner who was either in full time or part time employment or self employed at the time of interview was recorded and using the Standard Occupational Classification (OPCS, 1990) was classified into one of the Registrar General’s Social Class categories I to V. Social Class I represents Professional Occupation and Social Class V represents Unskilled Occupation. For the partners of consultants who were either retired, or a full time housewife/husband or were unemployed at the time of the interview, previous occupation was recorded and classified into the Registrar General’s Social Class categories. Two thirds of female consultants were married to, or living with, someone within the same Social Class compared to under half of male consultants (Table 5.16). A different pattern emerged for consultants who were divorced/separated or widowed. Half of the male consultants who were divorced/separated or widowed had been married to or cohabited with a partner in Social Class I (Table 5.17).
Table 5.16. Social class of consultant’s partner: currently married/cohabiting consultants

<table>
<thead>
<tr>
<th>Registrar General’s Social Class</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I - Professional</td>
<td>27 (36)</td>
<td>61 (69)</td>
<td>88 (54)</td>
</tr>
<tr>
<td>II - Managerial and Technical Occupations</td>
<td>37 (49)</td>
<td>26 (29)</td>
<td>63 (38)</td>
</tr>
<tr>
<td>IIINM - Skilled Occupations (Non Manual)</td>
<td>8 (11)</td>
<td>2 (2)</td>
<td>10 (6)</td>
</tr>
<tr>
<td>IIIM - Skilled Occupations (Manual)</td>
<td>3 (4)</td>
<td>0 (0)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>IV - Partly Skilled Occupations</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>V - Unskilled Occupations</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><em><em>75</em> (100)</em>*</td>
<td><strong>89 (100)</strong></td>
<td><strong>164 (100)</strong></td>
</tr>
</tbody>
</table>

Chi-square=20.61  P<0.001
* occupation not available in one case

The pattern for the partners of female consultants who were divorced or separated was the same as those female consultants who were currently married/cohabiting. However, the numbers are too small to make any reliable generalisations (Table 5.17).
Table 5.17. Social class of consultant's partner: divorced/separated/widowed consultants

<table>
<thead>
<tr>
<th>Registrar General's Social Class</th>
<th>Male Consultants No.</th>
<th>Female Consultants No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I - Professional</td>
<td>3 (50)</td>
<td>5 (50)</td>
<td>8 (50)</td>
</tr>
<tr>
<td>II - Managerial and Technical Occupations</td>
<td>3 (50)</td>
<td>4 (40)</td>
<td>7 (44)</td>
</tr>
<tr>
<td>IIINM - Skilled Occupations (Non Manual)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>IIIIM - Skilled Occupations (Manual)</td>
<td>0 (0)</td>
<td>1 (10)</td>
<td>1 (6)</td>
</tr>
<tr>
<td>IV - Partly Skilled Occupations</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>V - Unskilled Occupations</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>6 (100)</td>
<td>10 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>

Chi-square=0.68 Not Significant

Female consultants were more likely than male consultants to be married to, or living with, partners of high occupational status (Table 5.18 and Table 5.19). A quarter of female consultants were married to, or living with, partners who were employed in professional and managerial occupations compared with a third of male consultants who were married to, or living with, partners who were full time housewives or were not in employment (Table 5.18). Approximately a quarter of male and female consultants were married to, or living with, a medically qualified partner. However, the majority of partners of female consultants who were medically qualified were doctors, compared with a quarter of the medically qualified partners of male consultants who were nurses or working in professions allied to medicine (e.g. physiotherapy) (Table 5.19).
Table 5.18. Occupational status of consultants' partners

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Male Consultants No.</th>
<th>Female Consultants No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>30 (39)</td>
<td>44 (49)</td>
<td>74 (45)</td>
</tr>
<tr>
<td>Professional and Managerial</td>
<td>15 (20)</td>
<td>32 (36)</td>
<td>47 (28)</td>
</tr>
<tr>
<td>Other Occupations</td>
<td>4 (5)</td>
<td>5 (6)</td>
<td>9 (5)</td>
</tr>
<tr>
<td>Not in employment</td>
<td>27 (36)</td>
<td>8 (9)</td>
<td>35 (21)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>89 (100)</td>
<td>165 (100)</td>
</tr>
</tbody>
</table>

Chi-square= 18.31  P<0.001

5.3.2. Children

Over three quarters of consultants had children (Table 5.20). Female consultants were less likely to have children than male consultants (72% compared with 88%) (P < 0.01). The mean age for birth of first child was 32.5 years for female consultants and 32.7 years for male consultants. Given the traditional age difference for partners in which the husband is two to three years older than their wife, this suggests that women consultants were delaying childbirth for three to four years longer than their male counterparts. National figures for the United Kingdom shows that between the period 1964 to 1991 the average age that women had their first child increased from 24 years to 26 years for women (Family Policy Studies Centre, 1995). Compared with these figures, male and female consultants are having their first child at a much later age than the average age amongst men and women in the population of the United Kingdom.
### Table 5.19. Current occupation of consultant’s partners

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Consultants</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Hospital Medicine</td>
<td>11</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Public Health Medicine</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Medicine (SCMO)</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other professions allied to medicine (e.g. physiotherapy)</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dentistry</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Engineering</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Law</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Surveyancing</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Academic</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Professional and Managerial</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Publishing</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Advertising</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Computing</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Kitchen designer</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tourism</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Theatre</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Own business</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Coffee trader</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other Professional fundraising</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other Occupations</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hairdressing</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Childminding</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Housewife/husband</td>
<td>24</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>89</td>
<td></td>
</tr>
</tbody>
</table>
A third of consultant parents had children aged five years and under, which is particularly high for this age group who are between forty to fifty years (Table 5.21). However, women consultants were more likely than male consultants to have a child under five years of age (37% and 22% respectively), which again suggests that women consultants are delaying childbearing more so than male consultants (Table 5.21).

Table 5.20. Parental status of hospital consultants

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>One Child or more</td>
<td>76 (88)</td>
<td>84 (72)</td>
<td>160 (79)</td>
</tr>
<tr>
<td>No Children</td>
<td>10 (12)</td>
<td>32 (28)</td>
<td>42 (21)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

Chi-square = 7.63  P<0.01

Table 5.21. Age of youngest child

<table>
<thead>
<tr>
<th>Age of youngest child</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>0-5 years</td>
<td>17 (22)</td>
<td>31 (37)</td>
<td>48 (30)</td>
</tr>
<tr>
<td>6-10 years</td>
<td>27 (36)</td>
<td>27 (32)</td>
<td>54 (34)</td>
</tr>
<tr>
<td>11-16 years</td>
<td>25 (33)</td>
<td>17 (20)</td>
<td>42 (26)</td>
</tr>
<tr>
<td>17 years plus</td>
<td>7 (9)</td>
<td>9 (11)</td>
<td>16 (10)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>84 (100)</td>
<td>160 (100)</td>
</tr>
</tbody>
</table>

Chi-square=5.47  Not Significant
5.3.3. **Family Life of Teaching Hospital Consultants**

It would be expected that the characteristics of teaching hospital consultants may be different from district general hospital consultants because of the different demands of the job. In particular, involvement in research and teaching commitments tends to be undertaken during the evenings and weekends, outside clinical practice hours, which may affect the family life of hospital consultants. Nearly a third of female consultants in teaching hospitals were single compared with no male consultants in teaching hospitals (Table 5.22). Female consultants in teaching hospitals were more likely to be single than female consultants in district general hospitals (23% and 12% respectively) (Table 5.23). This suggests that achieving senior grade in the upper echelons of the medical profession may have a greater effect on personal and family life of women than men.

**Table 5.22. Marital status of teaching hospital consultants**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>(0)</td>
<td>7</td>
</tr>
<tr>
<td>Married/Cohabiting</td>
<td>16</td>
<td>(84)</td>
<td>18</td>
</tr>
<tr>
<td>Divorced/Separated/Widowed</td>
<td>3</td>
<td>(16)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>(100)</td>
<td>26</td>
</tr>
</tbody>
</table>

Chi-square = 7.20  Not Significant
Table 5.23. Marital status of female consultants according to type of hospital

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>London Teaching Hospital No.</th>
<th>District General Hospital No.</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>6 (23)</td>
<td>11 (12)</td>
<td>17 (14)</td>
</tr>
<tr>
<td>Married/Cohabiting</td>
<td>19 (73)</td>
<td>70 (78)</td>
<td>89 (77)</td>
</tr>
<tr>
<td>Divorced/Separated/Widowed</td>
<td>1 (4)</td>
<td>9 (10)</td>
<td>10 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100)</td>
<td>90 (100)</td>
<td>116 (100)</td>
</tr>
</tbody>
</table>

Chi-square=2.56  Not Significant

Male teaching hospital consultants married at an earlier age than female teaching hospital consultants (27.9 and 30.4 years respectively). Female teaching hospital consultants were less likely than male teaching hospital consultants to have children (27% and 5% respectively) (P<0.05). Although the mean age for birth of first child was similar for male and female teaching hospital consultants (men=33.1 years, women=34.5 years), given previous comments on the traditional age difference between partners, women teaching hospital consultants had children at a relatively later age then male teaching hospital consultants (Table 5.24) and at a later age than female consultants in district general hospitals.
Table 5.24. Mean age for birth of first child according to type of hospital consultant

<table>
<thead>
<tr>
<th>Type of Consultant</th>
<th>Male Consultant (mean age in years)</th>
<th>Female Consultant (mean age in years)</th>
<th>Total (mean age in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District General Hospital</td>
<td>31.8</td>
<td>31.9</td>
<td>31.8</td>
</tr>
<tr>
<td>Teaching Hospital</td>
<td>33.1</td>
<td>34.5</td>
<td>33.8</td>
</tr>
<tr>
<td>All</td>
<td>32.7</td>
<td>32.5</td>
<td>32.6</td>
</tr>
</tbody>
</table>

5.4. Summary

In summary, the sample of consultants consists of a slightly younger group of female than male consultants. The majority of consultants achieved consultant grade during their mid thirties and overall female consultants achieved consultant grade at least one year earlier than their male colleagues in the same speciality. The majority of consultants were working full time in a district general hospital and, on average, had been working as a consultant for seven to eight years.

The majority were married, although more women than men were single. Women consultants married at a later stage in their career than male consultants. Female consultants were more likely than male consultants to be married to, or living with, men of high occupational status. The majority of consultants became parents for the first time during their early thirties. Female consultants were more likely than male consultants to be childless. Female consultants had their first child at a later age than male consultants, suggesting considerable delay in family formation amongst female
The average age for marriage and childbirth for both male and female consultants was significantly later than the national average age amongst the population of the United Kingdom. Female teaching hospital consultants married at a later age than male teaching hospital consultants and both male and female teaching hospital consultants became parents during their early thirties. The marriage and parenting patterns of hospital consultants differs from men and women in the population of the United Kingdom and differs between male and female consultants. The extent to which family formation patterns were influenced by professional life and why will be discussed in chapter six.
CHAPTER 6

The Effect of a Hospital Medical Career on the Family Life of Hospital Consultants

The culture within many organisations is based on a full time continuous job model which focuses on organisational discourses of time, where long hours are valued as a sign of commitment (Lewis, 1997). The organisational culture within Hospital Medicine is highly dependent on this type of model. In comparison to other professions, hospital doctors provide on call emergency cover, which involves time spent in the hospital at weekends and evenings. Consequently, the professional life of a hospital consultant consumes a large part of his or her personal life. This chapter will focus on one key question; what effect does a hospital medical career have on the family life of consultants and why?

The first two sections of this chapter examine the effect of training to be a consultant on developing a relationship and on childbearing. This sample includes 'successful' consultants who have achieved consultant grade and it is quite likely that the gendered effects of combining a hospital career and family life are much greater for women doctors who do not attain consultant grade and become associate specialists, staff grade doctors or leave Hospital Medicine. The latter part of this chapter examines the effect of being a hospital doctor on the family life of consultant parents, both while they were training and as consultants.
6.1. Developing and Maintaining Relationships

Female consultants were more likely to be single than male consultants (14% and 5% respectively) as shown in chapter five. Remaining single was closely associated with the demands of a hospital career during the training years, which had led to difficulty forming relationships for the majority of single female consultants. Key factors were the long hours during the training years, geographical moves which had led to the breakdown of relationships and, in some cases, difficulty in developing relationships because of being perceived as a professional woman.

The working practices in Hospital Medicine at the time consultants in this study were training were based on spending the majority of working and non working hours in the hospital. Social life was also organised around the hospital environment, either in the hospital bar or social activities organised by the Doctor’s Mess. Consequently the opportunity to meet potential non medical partners was limited for some female consultants. The same difficulties were not evident amongst the male consultants, only 5 per cent were single.

"I had two quite serious relationships where the people to a certain extent weren’t able to cope with me working the sort of hours I did and in the end I decided that it was more important to me to stay with my career." **093, single female consultant, childless, medical speciality**
"I do think the fact that I was working so hard and seen as a professional woman interfered with my ability to develop relationships." 101, single female consultant, childless, medical speciality

Single female consultants had made choices between their relationships and their career during their training years,

"Not in later years but I think in earlier years I made decisions about my relationship because of my job and my training, because of travelling, having to choose between a relationship and a job at that time." 206, single female consultant, childless, surgical speciality

"Medicine restricts your mobility and the further up the ladder, the less mobility because of the number of jobs - consultants are not like GPs. Also if I moved I would have been an outsider, if there were internal candidates. This was the relationship where settling down and family were important. This was a crucial relationship and time for me. He needed to move to Cardiff, there was no job for me... this was the nightmare you never wanted to be in "is my career more important than my relationship?". For me I had a strong commitment to medicine and I was at the stage when I wanted a consultant post." 116, single female consultant, childless, medical speciality

The long working hours were detrimental towards maintaining relationships during training years,
"In a practical way, you miss things, you have to cancel things at the last
minute. In an emotional way you get involved in work, so you make less of
an effort with the rest of your life. You can't be bothered with the effort of
organising things." 137, single female consultant, childless, psychiatry
speciality

"I was doing a 1 in 2 or a 1 in 3 and studying. There was no time to do
anything. I was engaged but it broke up because my finance got fed up with
being stood up. He accepted it while I was a pre-registration house officer but
he didn't realise it went on." 209, single female consultant, childless, surgical
speciality

"1 in 2 rotas as a house officer restricts social life, there is not a great deal of
time outside to do other things. At the time I was so absorbed in it because it
was new and exciting. I just accepted that was what you had to go through in
order to become a doctor. It is only as you go on and on, one day you thought
it was all going to stop and it was going to be worth it and you were going to
have a wonderful social life after all. And that doesn't happen. It goes on
being hard in other ways. As you go up the ladder you are not in the hospital
for so many hours but you have other commitments, for example, writing
research papers, that you spend every waking hour that you're not in the
hospital doing things like that." 186, single female consultant, childless,
surgical speciality
"It is a strain if you are both working long hours. You don’t have enough time
to devote to the relationship. Most people work nine to five and have weekends
off." 046, single female consultant, childless, diagnostic speciality

There was also evidence that a hospital career had a detrimental effect on the marital
relationships of consultants. In particular, one theme that emerged from the data was
that a hospital career had caused strains on relationships, through not being home very
much, or through being tired and stressed because of work pressures.

"There were times when I’ve been busy when it has put pressure on our
marriage, as you would expect. There have been times when my husband has
felt really quite angry and jealous of the time my career has taken away from
him." 176, married female consultant, surgical speciality

"He hoped that when I became a consultant things would be easier but it
hasn’t. He says I work too much, what are other doctors doing?. He wants
to spend more time with me, he doesn’t mind if I take work home because
then I’m there." 175, married female consultant, surgical speciality

"My family would say it has not done them any good me being a professor.
It has taken me away psychologically. If I go on holiday I take work with me."
166, married male consultant, psychiatry speciality

"The stress of being a consultant had an influence on the breakdown of my
second relationship. I was a clinical director for four years and this was time consuming and contributed to the break up of my relationship." 068, single 

6.2. Effect on Childbearing Patterns

A hospital career had a greater effect on the childbearing patterns of female consultants than male consultants. The mean age for birth of first child was 32 years for male and female consultants, whereas nationally it is higher (see chapter five). Female consultants were less likely to have children (28%) than male consultants (12%) (see chapter five). A greater proportion of female consultants than male consultants became parents for the first time at consultant grade (35% and 21% respectively) (Table 6.1). The modal grade for birth of first child was registrar for male consultants but consultant for female consultants. This suggests considerable delay in childbearing for most female consultants.
Table 6.1. Medical grade at birth of first child

<table>
<thead>
<tr>
<th>Grade at Birth of First Child</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>House Officer</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Senior House Officer</td>
<td>10 (13)</td>
<td>13 (16)</td>
<td>23 (15)</td>
</tr>
<tr>
<td>Registrar</td>
<td>25 (33)</td>
<td>15 (18)</td>
<td>40 (25)</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>22 (29)</td>
<td>23 (28)</td>
<td>45 (29)</td>
</tr>
<tr>
<td>Consultant</td>
<td>16 (21)</td>
<td>29 (35)</td>
<td>45 (29)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100)</td>
<td>82 (100)</td>
<td>157*(100)</td>
</tr>
</tbody>
</table>

* Data not available for three cases
Chi-square=7.44  Not Significant

The majority of female consultants who became mothers at consultant grade say they had unintentionally delayed having children, however a minority, had either made a choice to delay children until completion of their training, or had been unsure about having children earlier in their career because of the potential detrimental effect on their career development. This was not evident amongst the male consultants.

"I delayed having children, I waited to be a consultant first. The advantages of having children later are you’re more stable...relationship, geographically, financially. But the downside is the children will be dependant, almost until you retire." 188. female consultant, surgical speciality, first child born at age 31 years
"I got well up the ladder before I had children. I got my MRCP and on to an approved training ladder and having got that far, I don’t think it made any difference. It was a conscious choice to wait to have children. A lot of disapproval existed." 274, female consultant, diagnostic speciality, first child born at age 30 years

Delaying child birth was closely associated with pressure to maintain a full time continuous career.

"I felt if I took time off for maternity leave my hospital career would be finished." 73, female consultant, medical speciality, lone mother, first child born at age 41 years

Half of male and female consultants had two children (Table 6.2). Although the family size of male and female consultants is similar, a minority of female consultants said they had less children than they would have preferred, because of the demands of work and family or because of delayed parenthood.

"I am disappointed. I would have liked to have at least one more child, but I got carried away with all those obstacles, in terms of registration, then catching up with membership exams and so on." 284, female consultant, psychiatry speciality, one child born at age 31 years
"The main influence it had on us was not having more children because I was so busy that we decided that ultimately we could just have one because we could give more time to one rather than spreading our time over more children. This choice was made based on my career, not initially but as time passed we decided to devote ourselves to one offspring." 176. female consultant surgical speciality, one child born at age 22 years

"I would have liked children earlier. I would have had the option of having a third, if I had children younger." 245. female consultant anaesthetics, first child born at age 38 years

Table 6.2. Family size of consultant parents

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>12 (16)</td>
<td>13 (15)</td>
<td>25 (15)</td>
</tr>
<tr>
<td>Two</td>
<td>38 (50)</td>
<td>45 (54)</td>
<td>83 (52)</td>
</tr>
<tr>
<td>Three</td>
<td>22 (29)</td>
<td>16 (19)</td>
<td>38 (24)</td>
</tr>
<tr>
<td>Four or more</td>
<td>4 (5)</td>
<td>10 (12)</td>
<td>14 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>84 (100)</td>
<td>160 (100)</td>
</tr>
</tbody>
</table>

Chi-square=5.96 Not Significant

Fifteen per cent of married or cohabiting female consultants did not have children compared with 8 per cent of male consultants. The constraints of a medical career were the reasons given for childlessness by over half of the female consultants (n=20, 63%) compared with only two of the childless male consultants. In particular, female
consultants did not have children because they did not know how they would have combined a career and children. The same conflict between children and career was not evident amongst male consultants.

"My career was a contributory factor in not having children, one should do what one feels is right at the time. I went to several interviews and I was asked if I was planning to get married, to have children and if so this would be a drain on the department. I didn’t consciously decide not to have children but I always felt uneasy about it. I didn’t know if there would be retribution."

201. female consultant, childless, surgical speciality

The stress experienced by hospital doctors has been discussed in previous research (Firth-Cozens, 1991; Ramirez et al, 1996; Swanson et al, 1996). This study did not attempt to measure stress levels amongst consultants. However, the qualitative data indicated that feeling stressed had a negative effect on family life. One effect of stress for a minority of female consultants was difficulty conceiving.

"I was actually trying to having a baby while I was a registrar but I was quite infertile and it took me five years to conceive. I didn’t actually plan to wait until I was a consultant before starting a family. Possibly the stress of work had a role to play in my infertility because I conceived eight weeks after getting my consultant post." 190. married female consultant, surgical speciality
"I tried for a baby ten years ago. I took a clinical medical officer job because it was nearer nine to five and less stressful and therefore I was more likely to have a baby. But I didn't, there was too much stress." 056, divorced female consultant, childless, medical speciality

"I was quite old when we married and we were very keen to have children but I didn't get pregnant so we saw a gynaecologist and had fertility investigations. However I didn't decide to go for IVF as I felt bad about taking time off work for it. Also the stress at work could have been the reason for me not getting pregnant." 119, married female consultant, childless, diagnostic speciality

6.3. Effect on Family Life

A third of consultant parents perceived their career had no effect on their family life. However, nearly half (46%) considered their career had a negative effect on their family life (Table 6.3). Slightly more male than female consultants considered their career to be a negative effect on their family life (49% compared to 44%). More women consultants than male consultants said their career had both a positive and a negative effect on their family life (19% and 9% respectively).
Table 6.3. Perceived effect of hospital career on the family life of consultant parents

<table>
<thead>
<tr>
<th>Perceived effect of career on family life</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive effect</td>
<td>5 (7)</td>
<td>4 (5)</td>
<td>9 (6)</td>
</tr>
<tr>
<td>No effect</td>
<td>26 (35)</td>
<td>26 (32)</td>
<td>52 (34)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>36 (49)</td>
<td>35 (44)</td>
<td>71 (46)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>7 (9)</td>
<td>15 (19)</td>
<td>22 (14)</td>
</tr>
<tr>
<td>Total</td>
<td>74 (100)</td>
<td>80 (100)</td>
<td>154* (100)</td>
</tr>
</tbody>
</table>

Chi-square=2.80 Not Significant
* data missing in 6 cases

Variation existed across the medical speciality groups regarding the effect that a medical career was reported to have had on family life. Consultant fathers in the psychiatry specialities and in obstetrics and gynaecology were most likely to consider their career had a negative effect on their family life (Table 6.4). Amongst consultant mothers, variation existed according to speciality. Consultants mothers in the surgical specialities were most likely to consider their career had a negative effect on their family life compared with consultant mothers in obstetrics and gynaecology who were most likely to consider their career had a positive effect on their family life (Table 6.4). These findings are surprising since it would be expected that consultant mothers in obstetrics and gynaecology would have similar experiences to consultant mothers in the surgical specialties since both specialities are acute specialities with long working hours and high levels on call commitment. However, the numbers are very small and no clear conclusions can be drawn.
Table 6.4. Perceived effect of a hospital career on family life by medical speciality group: consultant parents

<table>
<thead>
<tr>
<th>Effect of career on family life</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Positive effect</td>
<td>2 (25)</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>1 (5)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>No effect</td>
<td>1 (13)</td>
<td>8 (42)</td>
<td>11 (44)</td>
<td>6 (32)</td>
<td>5 (38)</td>
<td>3 (30)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>5 (62)</td>
<td>9 (47)</td>
<td>9 (36)</td>
<td>7 (37)</td>
<td>7 (54)</td>
<td>6 (60)</td>
<td>8 (67)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>0 (0)</td>
<td>1 (5)</td>
<td>4 (16)</td>
<td>5 (26)</td>
<td>1 (8)</td>
<td>1 (10)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>8 (100)</td>
<td>19(100)</td>
<td>25(100)</td>
<td>19(100)</td>
<td>13(100)</td>
<td>10(100)</td>
<td>12(100)</td>
</tr>
</tbody>
</table>

* Data missing for six cases so does not total 160
A hospital career was considered to have a negative effect on the family life of consultants for a number of reasons, including disruption to the stability of family life, due to frequent geographical moves, little time to spend with partners and children and disruption to family activities, in particular during the weekends and evenings.

6.3.1. On Call Commitments

The nature of a hospital career involves going into the hospital at weekends and an on call commitment which restricts family activities, by not being able to go away at weekends. In this way, a hospital career differs from other professions in which men and women are less likely to be restricted to one geographical area at weekends. On call work involves emergency cover, which led to family activities being disrupted to respond to work demands. This is the case for both male and female consultants.

"Occasionally (my daughter) will say "Mummy do you have to go to work now" and weekends are worse when she is expecting to play and I am on call...."I missed my son’s first birthday party because a child with a brain tumour needed urgent attention." 126, female consultant, medical specialty

"My career interferes with what the children are doing. My bleep went off three times at the National History Museum. For the children, mummy goes to the hospital at the weekend. We can’t visit people because mummy is on call. I resent the on call the most, because it affects them the most. I miss out
on going where I want to at weekends due to 1 in 2 on call. I don’t have time
to do normal things like visiting people, shopping, concerts, writing letters,
talking to my husband." 118, female consultant, medical speciality

6.3.2. Working Hours

Involvement in family life is closely linked to the social construction of time within Hospital Medicine. In Hospital Medicine, time spent working at the hospital is considered an indicator of commitment, which supports the argument by Lewis (1997) that organisational discourses of time are constructed in terms of "productivity, commitment and personal value" (p.17). Doctors who wish to progress rapidly to consultant grade need to spend a substantial amount of time at work. Pressure to work long hours and spend a considerable amount of time in the hospital was evident amongst both male and female consultants.

"It puts tremendous pressure on people. Doctors are put under pressure to spend a lot more time on medicine and hospital life than perhaps they ought to, because of the way we are trained in medical school. The training gives the expectation that you are happy to work eighty to a hundred hours in terms of getting experience you need to progress...it may mean you are exhausted and have nothing left for anyone else. Some weeks I am emotionally drained, exhausted." 273, male consultant, anaesthetics speciality

"I would look more seriously at how to get where I am now without losing
my wife. There is no doubt if I hadn't been competitive I would have been left behind. I would have ended up in general practice or a district general hospital. There was no doubt that I was following a pattern that was demanded if you wanted to end up in a teaching hospital but there is also no doubt that I enjoyed what I was doing. But the system demanded that I follow that course, there's no doubt about it."

106, male consultant, medical speciality

"It is a pity that medicine in this country, historically, has been so badly organised, that most clinicians in acute specialities work ridiculous hours, at the expense of their health and their families. But if you want to pursue a career in the acute specialities that's the way it is."

215, male consultant, surgical speciality

"We have no idea of a normal life.. go shopping with my wife etc. There is no opportunity to spend time with my family, important people."

038, male consultant, diagnostic speciality

The working practices of Hospital Medicine also reflect attitudes that doctors should spend a considerable amount of their non working time in hospital life if they are to be seen to be committed to their career, particularly within the surgical specialities and obstetrics and gynaecology.

"We need to stop (evening meetings) now. It is not necessary for all these medical meetings on a Friday evening. I think it is definitely wrong. People
need to have time that is definitely for them socially. As a junior you have to be seen at these meetings. I was working 1 in 2, if you're not on duty, on your evening off when you could spend time with your partner, you have to go to the meeting because your career depends on you being seen at all the right places, doing all the right things, presenting at meetings and how ridiculous. So I do think we have that wrong and I think the pattern of medical behaviour doesn't change." **228, female consultant, obstetrics and gynaecology**

A second aspect among under ten per cent of female consultants was the perceived effect that stress, caused by the pressures of work, had on their children.

"My children have seen me getting frantic over a clinical problem, worry and stress." **283, female consultant, psychiatry speciality**

"The children live in a very busy and stressed household which has an effect on them. I hope they will have been looked after, that it won't be upsetting for them. We run around, we never sit down. My older daughter is aware of me being busy, she complained that there wasn't enough time spent with us. I was upset about it, maybe I'm too busy and too tired for them." **080, female consultant, medical speciality**
6.3.3. **Geographical Mobility**

Frequent geographical moves were a key factor in hospital training at the time the consultants in this study were training. The current availability of rotational training schemes have reduced the frequency of geographical moves for doctors who are currently in training. Male consultants were more likely to have frequent moves for their career than female consultants, (half of male consultants compared to a third of female consultants) which reflects the greater proportion of male consultants who had non working partners, or who had partners who were able to move to a new geographical area, with minimal disruption to their career. In contrast, female consultants were more likely to be married to another professional which had led them to remain in one geographical area to benefit both careers.

These findings reflect the geographical area in which this study took place, where the number of job opportunities in one geographical area are greater, and there is also greater opportunity to commute back to the family home at weekends. Female doctors in other areas of the country where the options relating to geographical mobility are limited may have been less likely to achieve consultant grade.

"I made a conscious decision to stay in London, recognising that we had to find two medical jobs and there would be more in London and that’s how it panned out." 001, female consultant, dual doctor marriage, diagnostic speciality.
Male consultants were more likely to have more frequent geographical moves than female consultants. Frequent geographical moves were perceived by male consultants to have had a detrimental effect on their family life.

"John my eldest has moved all over the shop...there is a slight regret. John gets fed up if the furniture is moved." 170, male consultant, psychiatry speciality

"Frequent moves have put a lot of stress on the family. My ten year old has been the most affected by it because of the frequent change of schools, he’s now onto his third school. It really has been extremely hard but we just kept going basically." 178, male consultant, surgical speciality

"Unfortunately going from job to job it’s meant the boys changing schools, they haven’t liked it at all, losing their friends so they blamed me for having to move away from an area that they loved." 235, male consultant, obstetrics and gynaecology

In particular, geographical moves had a negative impact on the partners of male consultants. The partners of some male consultants had experienced social isolation when moving to new areas, with no family or friends nearby.

"In the early days my wife suffered. She was on her own with tiny children. It was a tough time. The strain of having sole care of the children. Socially
it was total isolation for my wife. She was an extrovert person but arriving in a new place with small children was hard for her. I recognise a strong debt to my wife and to the children."

6.3.4. Positive Effects of a Hospital Career on Family Life

Only 7 per cent of male consultants and 5 per cent of female consultants considered their career had been a positive effect on their family life (Table 6.3). Male consultants considered the positive aspects to be the financial benefits and the positive role model, they had provided for their children. The former reflects the benefits of a consultant’s salary, the latter is not particular to Medicine per se but reflects perceived success in a professional job.

Female consultants were more likely than male consultants to consider their career was both a positive and a negative effect on their family life (19% compared to 9%). The positive aspects were they felt their children had become more independent, their medical career had given them a sense of fulfilment, and similar to male consultants they felt their family had benefited from their salary and they had provided a positive role model for their children. All were closely associated with their role as a working mother, rather than Medicine per se.

"My career has had a good effect on my family life, in that I have a high standard of living. My family has enhanced my feelings and this has led to my enjoyment at work. It's bad because I'm too pressurised which has led
to a deterilous effect on relationships. There is not enough time to do things, apart from work." 285, married female consultant, psychiatry speciality

6.4. Being a Mother in a Male Dominated Profession

Attitudes towards parenthood in hospital medical culture affected the involvement consultant mothers had with their children at an early age. The majority of women felt pressurised to return to work in order to maintain a full time continuous career and short periods of maternity leave, experiences of working through maternity leave and no provision for locum cover were common. Lack of responsibility from the organisation to provide cover for maternity leave reinforces how parenthood and personal and family time is undermined in Hospital Medicine. The low value given to family time in Hospital Medicine is similar to other organisational cultures (Lewis, 1997).

"I experienced negative attitudes towards me from my colleagues (when I was pregnant). It was implied, not directly in what was said. No-one tried hard to get a locum to do my job. I was angry, what was offered was no good for a locum. So I worked during my maternity leave, I came in for meetings and I brought my baby." 136, female consultant, psychiatry speciality

"When I was having twins, I took six weeks off doing nights on call, but I went into work because of the changes. I was 39 years old and I already had one child at home but the hospital would not provide a locum for me so there
was no real choice. They told me that locums were for maternity leave for junior doctors not consultants, there was no choice for me." 223, female consultant, obstetrics and gynaecology

"I ran the clinic from the hospital bed four weeks before the baby was born. I had my baby during annual leave, I came back after annual leave. I took no maternity leave because I didn’t want to loose the chance of getting a consultant post." 086, female consultant, medical speciality

"I might not have gone back to work twice when they were only six weeks old. I was like a kamikarzee pilot, having to get back, otherwise there was a black mark against you. You more or less had to find your own locums."

279, female consultant, diagnostic speciality

The difference between being a mother and father while working in a male dominated profession is evident in how some female consultants felt they could not talk about their children at work, or take time off work if their children were ill. The majority of cases were during the training years and attitudes may be more flexible towards family problems for doctors currently in training.

"I felt desperately at work that I should never admit to having problems at work and I remember my male boss saying he was cancelling a clinic because the children were sick. I would never dare say that, so it was quite a strain."

277, female consultant, medical speciality
"I could never talk about my children at work. If I said my son was sick I would get comments implying I should be at home. All subtle comments. So you don’t tell anyone anything, you have to present a happy face." 136, female consultant, psychiatry speciality

There was also evidence of negative attitudes from male senior colleagues towards women who became pregnant and blame being attached to women for allowing other women to become pregnant.

"The first woman to get pregnant is the one who gets the blame for all the other women who get pregnant. On my current research project, one of my researchers is pregnant and when I see my colleague, who is an old style professor, he will comment about allowing the researcher to get pregnant. When I was pregnant last time, there were many researchers and senior researchers who were pregnant and I had to endure comments like, 'look what you have done' etc." 136, female consultant, psychiatry speciality

Although the consultants in this study had worked long hours during their career and had followed the expected codes of behaviour in medical culture, there was evidence that some consultants considered there is a need for a career structure which will benefit the family lives of doctors and a need for a change in attitude towards the construction of time being associated with commitment.

"It would be nice to have acceptance that spending more time with one’s
family was considered acceptable. I think that goes for men as well. I’m not asking more for women, I think it will benefit men as well. Men should realise that their families are being neglected."

014, female consultant, diagnostic speciality

"Attitudes and culture need to change and I think it will benefit women and men, make them realise that you don’t have to work horrific hours and perhaps they would spend more time with their families." 161, female consultant, psychiatry speciality

"I agree with training for junior doctors. We did it and it was okay, but I don’t think the juniors should go through it. Changes are needed to enable them to achieve what they can in their careers, without having to sacrifice everything else." 219, male consultant, surgical speciality

"More attention needs to be paid to the impact of medicine on junior doctors’ social life, family life. I want junior doctors not to make the same mistake."

106, divorced, male consultant, medical speciality

6.5. Summary

In summary, achieving consultant grade in Hospital Medicine had a greater negative effect on the ability of female consultants than male consultants to develop and maintain relationships during their twenties and thirties. Some single female
consultants had made choices between their career and their relationships in order to achieve consultant grade because they were constrained by male defined working practices during their training years. The same choices were not made by male consultants.

The male orientated working practices of Hospital Medicine had a greater negative effect on the family building patterns of women than men. Women were less likely to have children and more likely to delay parenthood until they had completed their training, than men. Parenthood had been delayed, intentionally, or unintentionally because of pressure to have a full time continuous career in order to achieve consultant grade. However, some women delayed having children to such an extent that being older created difficulties conceiving and they now regretted not having children. The need to follow 'male' definitions of work had been at great personal cost for some women consultants.

Half of the consultants parents perceived their career had been a negative effect on their family life. Slightly more consultant fathers than consultant mothers perceived their career had been a negative effect on their family life. Few consultant parents thought their career had been a positive effect on their family life. Long working hours, and time spent in the hospital in non working hours were required by consultants during their training years. Organisational discourses of time and on call commitments contributed to the negative effect that a hospital career had on the family life of both men and women. Frequent geographical mobility during the training years was perceived to be detrimental to family life. Male consultants had
moved more frequently than female consultants during their training years, which reflects the different family structures of male and female consultants.

Women consultants’ experiences of motherhood suggests that a 'male' occupational culture exists in Hospital Medicine. Women consultants took short periods for maternity leave, many women made their own locum cover arrangements, and were available to work during their maternity leave. These arrangements were closely associated with the need to compete equally with men. Further evidence of a 'male' occupational culture is provided by women’s experiences of motherhood when they returned to work after childbirth. Some women consultants were aware of not being able to talk about their children at work, particularly if their children were sick. This was associated with the detrimental effect this would have on their career progress, which had created additional stress and strain for some consultant mothers. Women in this study overcame these cultural and organisational barriers to achieve consultant grade, however it is likely that these barriers would have prevented many other women from achieving consultant grade.
Previous research has shown that the domestic life of professional men and women is very different (Wajcam, 1996a). Professional women are more likely to be single and more likely to be part of a dual career couple than their male colleagues (Silverstone and Ward, 1980; Spencer and Podmore, 1987). Similar findings have been shown for doctors (Allen, 1988, 1994). Comparing the work/family relationship for men and women in different family structures is likely to provide a better understanding of the nature of professional women’s careers. In this context, this chapter will focus on two main questions; (i) despite working in the same profession and at the same grade, to what extent does the domestic life of male and female consultants differ and (ii) what is the differential relationship between professional life and family life for male and female consultants in the same family structure?

7.1. Family Types

Consultants in this study could be classified into six distinct family types which I will refer to as (i) dual career, where both partners were working full time (ii) full time/part time - one partner working part time, either the consultant or his or her partner (iii) traditional - only male consultant working (iv) non traditional - only female consultant working (v) lone parent and (vi) single consultant with no dependant children. Only the first five types will be discussed in this chapter.
Significant gender differences occurred in the 'family types' of consultants. Forty eight per cent of female consultants were part of a dual career couple compared with nearly a third (28%) of male consultants (Table 7.1). Male consultants were more likely than female consultants to be part of a full time/part time or traditional family type. (P<0.001) (Table 7.1).

**Table 7.1. Family type amongst hospital consultants**

<table>
<thead>
<tr>
<th>Family Type</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.  %</td>
<td>No.  %</td>
<td>No.  %</td>
</tr>
<tr>
<td>Dual Career</td>
<td>24 (28)</td>
<td>56 (48)</td>
<td>80 (40)</td>
</tr>
<tr>
<td>Full time/Part time</td>
<td>24 (28)</td>
<td>24 (21)</td>
<td>48 (24)</td>
</tr>
<tr>
<td>Traditional</td>
<td>28 (32)</td>
<td>0 (0)</td>
<td>28 (13)</td>
</tr>
<tr>
<td>Non Traditional</td>
<td>0 (0)</td>
<td>9 (8)</td>
<td>9 (4)</td>
</tr>
<tr>
<td>Lone Parent</td>
<td>4 (5)</td>
<td>5 (4)</td>
<td>9 (5)</td>
</tr>
<tr>
<td>Single Person</td>
<td>6 (7)</td>
<td>22 (19)</td>
<td>28* (14)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td>116 (100)</td>
<td>202 (100)</td>
</tr>
</tbody>
</table>

* includes divorced, now living alone, plus never married consultants

Chi-square=55.82  P<0.001

Differences between the domestic lives of male and female consultants can be seen most clearly when comparing male and female consultants in the same speciality. The surgical specialities will be used to provide an example of these differences. The majority of female consultant surgeons were married to, or living with, men of the same occupational status, compared with the majority of male consultant surgeons who were married to, or living with, women of lower occupational status (Table 7.2).
Table 7.2. Current occupation of partner of consultant surgeons

**Female Consultant Surgeons**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Surgeon</td>
<td>4</td>
</tr>
<tr>
<td>Consultant Physician</td>
<td>2</td>
</tr>
<tr>
<td>Trainee Surgeon</td>
<td>1</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Dentist</td>
<td>1</td>
</tr>
<tr>
<td>Chartered Surveyor</td>
<td>2</td>
</tr>
<tr>
<td>Editor</td>
<td>1</td>
</tr>
<tr>
<td>Company Director</td>
<td>1</td>
</tr>
<tr>
<td>Coffee Trader</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

**Male Consultant Surgeons**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time Housewife</td>
<td>7</td>
</tr>
<tr>
<td>Consultant Physician</td>
<td>2</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
</tr>
<tr>
<td>Senior Lecturer (Medicine)</td>
<td>1</td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Fewer female surgeons had children (11 out of 17 female surgeons compared with 14 out of 15 male surgeons). The majority of male and female surgeons had children during their medical training (Table 7.3), and therefore had to combine child care responsibilities with their career. However, two thirds of male surgeons had partners who were full time housewives, while 91 per cent of female surgeons employed paid domestic labour and were responsible for organisation of this domestic labour (Table 7.4).
Table 7.3. Stage in career first child was born: consultant surgeons

<table>
<thead>
<tr>
<th></th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>During Training</td>
<td>10 (71)</td>
<td>7 (64)</td>
<td>17 (68)</td>
</tr>
<tr>
<td>Consultant Grade</td>
<td>4 (29)</td>
<td>4 (36)</td>
<td>8 (32)</td>
</tr>
<tr>
<td>Total</td>
<td>14 (100)</td>
<td>11 (100)</td>
<td>25 (100)</td>
</tr>
</tbody>
</table>

Table 7.4. Primary source of child care: consultant surgeons

<table>
<thead>
<tr>
<th>Primary source of child care</th>
<th>Male Consultant Surgeons</th>
<th>Female Consultant Surgeons</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Nanny</td>
<td>2 (14)</td>
<td>9 (82)</td>
<td>11 (44)</td>
</tr>
<tr>
<td>Partner</td>
<td>9 (64)</td>
<td>1 (9)</td>
<td>10 (40)</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>1 (7)</td>
<td>0 (0)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Childminder</td>
<td>1 (7)</td>
<td>0 (0)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Nursery</td>
<td>0 (0)</td>
<td>1 (9)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Relative</td>
<td>1 (7)</td>
<td>0 (0)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>14 (100)</td>
<td>11 (100)</td>
<td>25 (100)</td>
</tr>
</tbody>
</table>

The following section will discuss each of the five 'family types' in turn, including a discussion of dual doctor couples. Differences in the work/family relationship for male and female consultants in these family types will be explored.

### 7.2. Dual Career Families

Nearly a third (28%) of male consultants and nearly half (48%) of women consultants were in dual career families in which both partners were working full time (Table 7.1).
Forty four per cent of dual career couples were dual doctor couples (Table 7.5). The work/family relationship of male and female consultants in dual doctor couples will be discussed later in this chapter. The following section will examine the work/family relationship for other types of dual career couple. Fifteen male consultants and thirty female consultants were in a dual career couple (not a dual doctor couple) (Table 7.5).

### Table 7.5. Occupation of partner: dual career couples

<table>
<thead>
<tr>
<th>Occupation of Partner</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical - Doctor</td>
<td>9 (38)</td>
<td>26 (46)</td>
<td>35 (44)</td>
</tr>
<tr>
<td>Medical - Other</td>
<td>3 (12)</td>
<td>4 (7)</td>
<td>7 (9)</td>
</tr>
<tr>
<td>Professional and Managerial</td>
<td>10 (42)</td>
<td>21 (38)</td>
<td>31 (39)</td>
</tr>
<tr>
<td>Other Occupation</td>
<td>2 (8)</td>
<td>5 (9)</td>
<td>7 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (100)</td>
<td>56 (100)</td>
<td>80 (100)</td>
</tr>
</tbody>
</table>

Male consultants in dual career couples were less likely than female consultants in dual career couples to have children (20% compared with 13%) and less likely to have children under five years of age (13% compared with 30%) (Table 7.6).
Table 7.6. Parental status: dual career couples (not dual doctor)

<table>
<thead>
<tr>
<th>Parental Status</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>No children</td>
<td>3</td>
<td>(20)</td>
<td>4</td>
</tr>
<tr>
<td>0-5 years</td>
<td>2</td>
<td>(13)</td>
<td>9</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>10</td>
<td>(67)</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>(100)</td>
<td>30</td>
</tr>
</tbody>
</table>

Two types of work/family relationship were evident amongst male consultants in dual career couples. In the first type, male consultants worked longer hours than their partners, their career had greater priority than their partner and their partner undertook more of the child care, providing male consultants with greater freedom to devote to their work. In the second type, male consultants had reduced their professional activities because of the demands of their family life and both partner’s careers had equal priority. There were roughly equal numbers of male consultants in each type of work/family relationship. The first two quotes provide examples of the first type of work/family relationship, the third quote provides an example of the second type of work/family relationship.

"My wife supports me by enabling me to carry on working as I am, by taking some of the burden of child care. Child care support from my wife enables me freedom to work." 131, *male consultant, medical speciality, dual career family*

"My wife has moved at the expense of her career. She’d be a partner
otherwise. She may still be a partner, but she’s a bit old now." 236, male consultant, obstetrics and gynaecology, dual career family, married to a solicitor

"I wasn’t able to take a job (abroad) as director of postgraduate training. I would have been director of postgraduate training at an appalling young age and that would have done me a great deal of good. I didn’t take the job because of family commitments, I didn’t want to move small children. My wife was building up her practice and she couldn’t have built it up anywhere else but England because of the clientele.........I don’t think I could take my career much further than it is at the moment, given the level of family commitments that I have. I don’t really have the option of international travel. I can’t really be away from home for that long." 166, male consultant/professor, psychiatry speciality, dual career family

Three types of work/family relationship were evident among women consultants in dual career couples. The first type was the most common and included women consultants who worked longer hours than their partners, and typically their partner undertook more child care and had more contact with their children. Although, in this group there were also women consultants who undertook more child care than their partner, despite working longer hours.

"I couldn’t do my job without my husband’s help. He cooks meals, he has to get home to relieve the nanny because his hours are predictable, he has made
a lot of sacrifices." 126, female consultant, medical speciality, dual career family

"I'm not there as much as other mothers would be. During the weekdays my husband is home to play with (the children). The structure of our life is not the same as other childrens would be with their father taking the lead role and their mother being there less often." 223, female consultant, obstetrics and gynaecology, dual career family

"My husband is around much of the time now and my daughter understands that Mummy doesn't go to sports days or school plays, my husband goes instead." 051, female consultant, medical speciality, dual career family

An opposite pattern was evident in the second type of work/family relationship. Women consultants in this group had a partner who worked longer hours and women consultants had compromised their career goals or restricted their work involvement because of their family demands. This type of work/family relationship existed even for women consultant surgeons.

"At least twice a month I have evening meetings. It would be almost impossible if both of us were working horrendous hours. I think in any relationship to an extent one has to decide whose career is foremost. He earns more money than I do and so I limit things a bit to make it workable and to enable a good quality of life for the children." 086, female consultant, medical speciality, dual career family
"For my husband his job takes priority, he does what he wants unless I ask him to come home early. He attends all the meetings he needs to. It’s easier if one person has priority, it would be hard to take it in turns, there would be no continuity. It’s particularly hard for chaps to take time off, it's not thought well of." 185, female consultant, surgical speciality, dual career family

The third type of work/family relationship for women consultants in dual career couples involved greater equality between partners, where both careers had equal priority and both partners were equally involved in child care.

"Both parents work, we all fend for ourselves, both parents are in a similar situation. It can be done but you need to organise yourself. My sons clean the house, everyone does their own things...rotas etc." 127, female consultant, diagnostic speciality, dual career family

In summary, greater equality in occupational status between partners was an advantage for some women consultants in dual career families because it led to greater equality in the domestic sphere. However, it was not for some male consultants in dual career families who were less involved in their professional work because of their greater family demands as a result of having a full time working partner.
7.3. **Full Time/Part Time Families**

The work/family relationship is very different for male and female consultants in full time/part time families. All male consultants in full time/part time families were working full time and their partner was working part time, and was primarily responsible for child care, allowing them greater freedom to work (Table 7.7).

**Table 7.7. Employment status of consultant’s partners in full time/part time families**

<table>
<thead>
<tr>
<th>Employment status of partner</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Partner part time</td>
<td>24</td>
<td>(100)</td>
<td>3</td>
</tr>
<tr>
<td>Partner full time</td>
<td>0</td>
<td>(0)</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>(100)</td>
<td>24</td>
</tr>
</tbody>
</table>

Chi-square=37.33  P<0.001

"My wife worked part time to look after the kids. She was encouraging in my applying for jobs and she was flexible."  **026, male consultant, diagnostic speciality, fulltime/part time family**

"Because my wife is part time she can help me out with work when things are extra busy."  **039, male consultant, diagnostic speciality, fulltime/part time family**
In contrast, the majority of female consultants in full time/part time families were working part time, had a full time working partner and were primarily responsible for child care (Table 7.7).

"He was keen for me to have Mondays off because he felt we were both too busy and it would ease the load on him. If I had the day off it would be less stressed at weekends and this would ease the load on him." 080, female consultant, medical speciality, fulltime/part time family

"I was not good at meeting the children’s needs so I went part time. I can be flexible workwise, he can’t, so I’ve shouldered the responsibility." 012, female consultant, diagnostic speciality, full time/part time family

The majority of male consultants in full time/part time families had career priority compared with two thirds of female consultants in full time/part time families whose partners had career priority.

"We decided to have children, so my career came first because the system is such that it doesn’t enable her to work and have children. She decided to put her career second." 255, male consultant anaesthetics, full time/part time family

"There was always the assumption that his career would be first and I would find a part time post to fit in around him, so my career wasn’t really supported
by him at all." 241, female consultant, anaesthetics, full time/part time family

In summary, the work/family relationship for male and female consultants in full time/part time families, seems to be beneficial to the careers of male consultants but not to the careers of female consultants, because greater inequality in occupational status led to greater inequality in the domestic sphere.

7.4. Traditional and Non Traditional Families

Thirty two per cent of male consultants were part of a traditional family type, i.e. they had a partner at home who was a full time housewife compared with only 8 per cent of female consultants who were part of a non traditional family type who had a partner at home full time. Male consultants in traditional families and female consultants in non traditional families have theoretically similar domestic situations, because both are primary wage earners and have partners providing domestic support at home. However, the relationship between work and family roles is very different for male and female consultants even amongst traditional and non traditional family types. Female consultants have more involvement in child care and domestic labour than male consultants.

Case one provides an example of a female consultant in a non traditional family, whose husband is at home providing full time domestic support. It illustrates how gender inequality in domestic labour persists, despite differences in the occupational status of both partners. The names in the case studies are fictional.
**Case 1: Dr Ann White**

Dr Ann White is a consultant anaesthetist and works in a London teaching hospital. She currently works full time and is the main wage earner in her family. Her husband is unemployed, and provides full time domestic support by looking after their two children under five years old. Despite working full time, Dr White undertakes more child care than her husband. Her ability to work long hours is constrained by her family demands because she takes over from her husband in the evenings, so that he can attend meetings relating to the voluntary work he does.

"There is friction between us. He is at home with the children. He has meetings to attend in the evenings on a voluntary basis, so there is pressure on me to return home early. We pay for child care when I have to work late. I pick up the children from child care".

Her family demands have constrained her ability to be involved in extra professional activities.

"I'm not doing background work that I should be and it affects the way I'm perceived by my peers...how useful I am. I might be a better doctor if I didn't have children. I would read more and be more involved in politics, better tutorials etc., who knows what one might have done. I'm unlikely to get a merit award."

Case two provides an example of a male consultant in a traditional family and illustrates how men in traditional family types appeared to have greater freedom, to devote time to their work, than women consultants in non traditional family types, because they are less involved in child care and domestic labour.
Case 2: Dr Simon Lyons

Dr Lyons is a consultant anaesthetist in the south east of England. He is married with three children under ten years old. His wife has been a full time housewife since the children were born. Dr Lyons spent much of his training years working away from home during the week and commuting back to his family at weekends, which he was able to do, because his wife was providing full time domestic support. He says,

"At one stage I was working away from home for the best part of a year and then I was on call for the weekend. That would be the week of work before the on call weekend and then the week of work after the on call weekend and so I wouldn't be home for two weeks. I think it has been pretty tough for her over the years to be honest."

Dr Lyons' lower involvement in domestic labour and child care is reflected in his comments about his wife's greater involvement in child care in the week day evenings.

"Getting the kids to bed at 6, 7, 8 o'clock, it would be nice to have someone else at home to deal with three small kids. Hands on help. Quite often when I get home, she's already got them to bed. Sometimes I think she wished I got home a bit earlier."

In summary, the careers of women in non traditional families and male consultants in traditional families were given high priority because they were the primary wage earner in their family, which enabled women to take the lead, in terms of moving to new geographical areas for their job. However, gender inequality persists in domestic labour and child care for women in non traditional families which was associated with lower involvement in their career. In contrast, male consultants in traditional families...
were able to organise their work to benefit their career, in terms of living away from the family home and spending long hours at work.

7.5. Lone Parents

The work/family relationship for lone consultant parents is likely to be more complex than for consultants in other family types because of the greater family demands of lone parents. It is therefore interesting to examine how lone consultant parents manage their career and family demands. There were five lone consultant mothers and four lone consultant fathers in the sample. Lone parent in this study refers to "a lone parent living with his or her never married dependant children" (General Household Survey). I have also included one consultant mother who had been a lone parent for most of her career but her children were aged over eighteen and no longer dependant.

The majority of lone parents were divorced, but one male consultant and one female consultant were never married lone parents. The majority became a lone parent during consultant grade, although two lone mothers and one lone father were lone parents for the majority of their career. Lone mothers had slightly younger children than lone fathers (Table 7.8).

Provision for child care is a key theme amongst lone consultant parents. The nature of hospital work means that consultants cannot leave their work in an emergency, therefore, good child care arrangements are vitally important for lone consultant parents. Consultants work long and unpredictable hours which means that some forms
of child care, such as childminders or nurseries, are not an option. Nannies or housekeepers are costly, particularly since they are likely to need to be well paid to cover for unpredictable and long working hours. Although hospital consultants earn a substantial salary, this type of child care is costly which is a burden for both male and female lone consultant parents because they only have one earner in the household.

"I work in the NHS, private sector and run my own practice so I need someone there. It’s a vicious circle, one is making the money to pay the person to go and make the money. I couldn’t do my NHS work if I didn’t have a housekeeper. I am able to work more flexibly than if I had a childminder and I had to leave at five pm". 259, male consultant, anaesthetics speciality, lone consultant father

"Medicine eats into every area of your life. Compared with other professionals for example, solicitors, consultants are underpaid. I would rather have a nanny than an au pair but I can’t afford it"163, female consultant, psychiatry speciality, lone consultant mother

In summary, gender differences were less evident amongst lone consultant parents in contrast to differences between male and female consultants in other family structures. Both lone consultant mothers and lone consultant fathers experienced difficulties in providing high quality child care because they were the only earner in the household.
### Table 7.8. Characteristics of lone consultant parents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Lone Mothers</th>
<th>Lone Fathers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Employment Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Part time</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Medical Grade became a lone parent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHO</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Registrar</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Consultant</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Number of years as lone parent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 5 years</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>5-7 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8-12 years</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Age of youngest child</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 5 years</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6-10 years</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>11-16 years</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Main source of child care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childminder</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Au pair</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>After school club</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neighbour</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
7.6. Dual Doctor Couples

A third of consultants were in dual doctor couples (n=60, 30%). Women consultants were more likely than male consultants to be married to, or living with, another doctor (35% and 22% respectively). Across the medical specialities, male consultants in the medical, diagnostic and anaesthetics specialities were more likely to be married to or living with, another doctor. However there was no difference for women consultants according to speciality group apart from a lower percentage of dual doctor couples amongst women consultants in the medical specialities (Table 7.9).

Table 7.9. Percentage of consultants who are dual doctor couples by medical speciality group

<table>
<thead>
<tr>
<th>Medical Speciality Group</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>3</td>
<td>(30)</td>
<td>11</td>
</tr>
<tr>
<td>Medical</td>
<td>8</td>
<td>(28)</td>
<td>7</td>
</tr>
<tr>
<td>Surgical</td>
<td>3</td>
<td>(20)</td>
<td>8</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>(8)</td>
<td>7</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>0</td>
<td>(0)</td>
<td>4</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>4</td>
<td>(29)</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>(22)</td>
<td>41</td>
</tr>
</tbody>
</table>

Over half (61%) of the dual doctor couples were dual hospital doctor couples. Slightly more women consultants than male consultants were married to another hospital doctor (66% compared to 53%) (Table 7.10).
Table 7.10. Type of dual doctor couples

<table>
<thead>
<tr>
<th>Occupation of Partner in Dual Doctor Couple</th>
<th>Male Consultants No. %</th>
<th>Female Consultants No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant (Hospital Medicine)</td>
<td>10 (53)</td>
<td>27 (66)</td>
<td>37 (61)</td>
</tr>
<tr>
<td>Non Career Grade (Hospital Medicine)</td>
<td>3 (16)</td>
<td>1 (2)</td>
<td>4 (7)</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>3 (16)</td>
<td>7 (17)</td>
<td>10 (17)</td>
</tr>
<tr>
<td>Public Health Physician</td>
<td>1 (5)</td>
<td>0 (0)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Community Medicine (i.e. SCMO)</td>
<td>1 (5)</td>
<td>0 (0)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Other (i.e. industry/army/retired)</td>
<td>1 (5)</td>
<td>6 (15)</td>
<td>7 (12)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19 (100)</strong></td>
<td><strong>41 (100)</strong></td>
<td><strong>60 (100)</strong></td>
</tr>
</tbody>
</table>

In over half of the dual doctor couples, both partners were working full time (58%) (Table 7.11). However, 47 per cent of the partners of male consultants in dual doctor couples were working part time, compared with 63 per cent of the partners of female consultants in dual doctor couples were working full time (Table 7.11). The partners of the two women in non traditional families were older and were retired from medical practice (Table 7.11).
Table 7.11. Family structure of dual doctor couples

<table>
<thead>
<tr>
<th>Family Structure</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Dual Career</td>
<td>9</td>
<td>(47)</td>
<td>26</td>
</tr>
<tr>
<td>Full time/Part</td>
<td>9</td>
<td>(47)</td>
<td>13</td>
</tr>
<tr>
<td>Traditional</td>
<td>1</td>
<td>(5)</td>
<td>0</td>
</tr>
<tr>
<td>Non Traditional</td>
<td>0</td>
<td>(0)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>(100)</td>
<td>41</td>
</tr>
</tbody>
</table>

Chi-square=4.52  Not Significant

The relationship between work and family roles of dual doctor couples involves two opposing aspects. Marriage to another doctor both decreases and increases work/family role conflict. Conflict is decreased through the understanding and knowledge of the work demands experienced by the other partner but is increased by the multiple pressures of work and family roles which exist within a dual doctor family. However this relationship is gendered, a dual doctor marriage is considered to be more beneficial by women consultants than male consultants. Amongst women consultants, marriage to another doctor decreased conflict between work and family roles, due to their partner’s understanding of a hospital doctor’s work commitments whereas for male consultants who were married to another doctor it was the reverse.

"It is of benefit being married to a paediatric surgeon. We can talk about work, we can quickly off load, we can bounce off one another. I can totally understand when Daniel goes in a Saturday morning, he promises to be back.
by lunchtime but doesn't actually get home until midnight."

216. female consultant, surgical speciality, dual hospital doctor couple

"We're both doctors and we both have careers in hospital medicine. I'm sure that's why we're still together, otherwise it would be very difficult. Sometimes my husband doesn't get home until very late and I know perfectly well what he's doing, but it doesn't make it any easier, especially if you're sitting in a concert with an empty seat. I think if I didn't have a job it wouldn't last." 013. female consultant, diagnostic speciality, dual hospital doctor couple

"Being married to another doctor, we've always understood what it's like to be dog tired when we get home. I don't think there is any other profession which can understand what it is like." 220. female consultant, obstetrics and gynaecology, dual hospital doctor couple

In comparison to women consultants, male consultants in dual doctor couples considered marriage to another doctor to be less beneficial because of the additional pressures it created in family life. The comparison for male consultants was with their colleagues whose partners worked part time, were housewives, or worked full time in lower status jobs with less pressure from conflicting family and professional roles than doctors who were married to another doctor. There was a clear status and power differential of the male consultant in relation to his wife which was less clear amongst male consultants married to other doctors.
"I think having a wife in medicine is detrimental in some respects, in the sense that with a wife who works, you're under pressure time wise, a wife who doesn't work can take the pressure off you." 122, male consultant, medical speciality, dual doctor couple

However, male consultants considered being married to, or living with a medically trained partner, or someone raised in a medical family was beneficial to their career if they stopped working or were working part time, and were providing domestic support at home as well as having an understanding of medical practice.

"My wife is very happy with her lifestyle working part time. She enjoys part time work a lot, she is a good manager. She supports me by talking through work and acts as social secretary, arranges going out to the theatre, meeting friends etc. As a GP from a doctor’s family she understands the job." 077, male consultant, medical speciality, fulltime/part time family

My wife’s father is a doctor and she’s been a medical secretary, so she understands what the work entails in terms of commitment and out of hours work and so on, so that hasn’t produced any stress that it may do." 177, male consultant surgical speciality, traditional family

"You can’t do a career in medicine unless you have a supportive partner, almost impossible. She looks after the children and she looks after the house. My wife says unless you were a nurse or someone with medical training you
would never tolerate it." 210, male consultant, surgical speciality, married to a nurse, full time/part time family

Three strategies were adopted by female consultants in dual doctor couples to manage the relationship between work and family life, which I will refer to as; (i) accommodating strategy, (ii) childfree strategy and (iii) segregation strategy. I will use case studies for each strategy to illustrate how these strategies were applied in the case of individual couples. The names used in the case studies are fictional.

(i) Accommodating strategy

An accommodating strategy typically involves female consultants who accommodated their working pattern to support their partner’s career and manage their family demands. There were no examples of an accommodating strategy adopted by male consultants. There were two types of accommodating strategy;

(i) family and work roles were combined during training and the work roles of the female consultant were accommodated for family demands. Typically the female consultant worked part time, took a career break or worked in a sub consultant grade. In most cases the male doctor’s career took priority.

(ii) family roles were delayed until near completion of training to maximise career development of both doctors after which family roles were accommodated by adoption of flexible work patterns by female consultants.
After the birth of their first child, female consultants transferred to higher levels of family involvement and lower levels of work involvement.

Case three provides an example of an accommodating strategy where family and work roles were combined during training.

**Case 3: Drs Mark and Catherine Whitely**

Dr Mark Whitely is a consultant anaesthetist and his wife is a locum general practitioner. They have three school age children. Their first child was born when Dr Mark Whitely was a senior registrar and his wife was an SHO. Prior to marriage the Whiteleys lived and worked in different parts of the country for two years. During their first year of marriage they lived for a period of time in different countries because of their work. Dr Catherine Whitely was a trainee in Hospital Medicine however when her husband moved to the South East of England after obtaining a consultant post, Dr Catherine Whiteley followed him and began working as a clinical assistant for eight years, which combined with the birth of their second and third child.

The Whiteleys are an example of how one career took priority and the career of the female doctor in the partnership was affected by her husband's career, combined with having children at an early stage in her career.

Case four provides an example of an accommodating strategy where family and work roles were delayed until near completion of training.

**Case 4: Drs Susan and Richard Bailey**

Dr Susan and Richard Bailey work in the South East of England. Dr Susan Bailey is a hospital
consultant in the medical specialities and her husband is a general practitioner. Their relationship began during their early training years and they married in their mid thirties when Dr Susan Bailey was a consultant and her husband was training to be a general practitioner in Wales. They have two children. Their first child was born one year after Dr Susan Bailey achieved consultant status. Dr Susan Bailey had worked full time throughout her medical training and continued to work full time after the birth of their child. Four years after their marriage Dr Richard Bailey moved to the South East of England, for a new post as general practitioner. Dr Susan Bailey followed her husband, leaving behind her consultant post of five years. Following their move, Dr Susan Bailey took a three year career break from medicine, during which their second child was born. After her three year career break, Dr Susan Bailey obtained a part time consultant post nearby their family home. She chose to work part time to balance her work and family roles and had been able to negotiate the consultant post she wanted. She says;

"By working part time I balance work and domestic commitments. I don't do weekends on call because my husband is on call......to have both of us on call would be intolerable. My career impinges on the children a lot less than my husband's career."

Despite her career being more established, Dr Susan Bailey's career development was compromised to minimise conflict between her own work goals and her family demands. This situation illustrates how female consultants who adopted an accommodating strategy adapted their work role to accommodate their family demands and negotiation of two medical careers led to disruption to the female consultant's career.

Case five provides a second example of how accommodating strategies were adopted amongst a dual doctor couple in the same speciality. This case illustrates how the female consultant changed her work role to accommodate her family demands, despite
being at the same stage along the career path as her husband.

Case 5: Mr and Mrs Ann and Daniel Henderson

Mr and Mrs Ann and Daniel Henderson both work as consultant surgeons in the London area. They have two school age children, the first was born towards the end of their higher professional training when the Hendersons were working in research posts. Dr Ann Henderson currently works part time and her husband works full time.

Mr and Mrs Ann and Daniel Henderson spent a large part of their early training years working in different parts of the country to enable both doctors to pursue their careers. Mrs Henderson says;

"I had a mad married life. Daniel was doing research in Sheffield, I was in Coventry, the house was in London, so we existed on that existence, which others might think a bit strange."

Conflict between career development and family demands reached its most difficult period when both doctors were looking for senior registrar grades in the north of the Region. Mr Daniel Henderson found his senior registrar post first and his wife was able to follow her husband and get her own senior registrar post by joining the PM(79)3 part time training scheme. This scheme also enabled her to follow her husband to the south of England when he got his consultant post, without jeopardising any of her training. Despite the career development of both doctors being considered, Mrs Ann Henderson experienced conflict in combining her career with her husbands. She says;

"If Daniel hadn't got the Leeds job, there might have been problems. I never fought him for a senior registrar job because that might have destroyed our marriage. I
Strategies to minimise conflict between work and family roles include a live-in nanny who is available to provide childcare during the middle of the night if both doctors are called into the hospital. Adoption of an accommodating strategy enabled both doctors to complete their medical training. The conflict between work and family roles are minimised by Mrs Ann Henderson adapting her work schedule to accommodate her family demands, while her husband devotes the majority of his time to his career.

(ii) Childfree Strategy

A childfree strategy typically includes couples where both doctors have high work involvement and full time continuous careers. Decisions about job searches have been based on the opportunity to benefit the career development of both doctors. Typically female consultants who adopted a childfree strategy do not have children, either intentionally or unintentionally, and have low involvement in their home life. This type of strategy does not privilege either partner but the result is a greater disadvantage for women who don't have children.

Case 6: Dr Mary Clifford and Mr Stuart Clifford

Dr Mary Clifford is a consultant radiologist and her husband is a consultant surgeon. They do not have any children and both work in the London area. They began living together as students and married during their higher professional training and spent the majority of their
training years in London. From the beginning, both careers took equal priority and one strategy to make this possible was to limit their job searches to the London area.

"I never considered being out of London, because my husband was here. If there is two of you in medicine, there's more of a chance of you both getting a job. If my husband had applied for a job outside London I wouldn't have gone. He always knew and I knew that we had to stay in London. If he got a job elsewhere I wouldn't have gone with him. We would have looked upon it as a temporary situation."

The conflict between career involvement and potential family roles are illustrated in the following quote by Dr Mary Clifford when she talks about children.

"There was a time ten years ago, I may have wanted to settle down and have children, but I knew I wanted a consultant job so I didn't and then about four or five years ago I thought "well nothing's going to happen now" and then the consultant job came up and I felt very loathed to have children when you step into a new job and now I think, well we're doing quite well without them, perhaps I don't want children."

(iii) Segregation Strategy

A segregation strategy typically includes couples where female consultants have high levels of work involvement and also have children. The work and family roles of female consultants were highly segregated and high levels of paid help were employed to manage child care and domestic labour, to substitute the female consultant's domestic labour and in this type of couple, the involvement of male doctors in domestic labour and child care was generally low.
Case 7: Mrs and Dr Miriam and Simon Spencer

Mrs Miriam Spencer is a consultant obstetrician and gynaecologist and her husband is a consultant anaesthetist. They married during their early training years and remained in London during their training and both obtained consultant posts in the London area. Both worked full time during their training and continued to do so after the birth of their child when Mrs Miriam Spencer was in the final year of her senior registrar training and her husband was working as a consultant. They have one child aged under five years. External support structures such as a nanny and a cleaner enable Mrs Miriam Spencer to have high work involvement. Mrs Miriam Spencer explains;

"by employing someone to nanny and clean, the dogsbody work, this means the time we are off we spend with our daughter, so we have a very good life and lifestyle."

Clear division between work and family roles, enabled Mrs Miriam Spencer to have a full time continuous career and high work involvement in an acute speciality.

In summary, a gendered relationship between work and family exists amongst dual doctor couples. Greater equality in occupational status is of benefit to women but not to men. Marriage to another working doctor for men was less beneficial than marriage to a non working or part time working spouse who was medically trained or someone raised in a medical family. In contrast, marriage to another working doctor for women was beneficial because it decreased conflict between professional and family roles. Adopting a segregated work/family relationship seemed to be the most successful strategy for women in dual doctor couples because it involved less compromise in professional and family roles than adopting a childfree or an accommodating strategy.
7.7. Summary

In summary, to achieve consultant grade in Hospital Medicine requires considerable commitment to work and involvement in professional life. Despite working in the same occupation and at the same grade, male and female consultants have very different domestic circumstances. Male consultants are more likely to be part of a traditional or full time/part time family type, compared with female consultants who are more likely to be part of a dual career family. The relationship between work and family life is different for male and female consultants in the same type of family structure.

Analysis of data on the work/family relationship for male and female consultants in dual career couples indicates that there were rarely cases where both partners had equality in occupational status and equality in the domestic sphere. Some female consultants found greater equality in occupational status an advantage because it led to greater equality in the domestic sphere. However, the reverse was true for some male consultants because they were less involved in their professional work because of their greater family demands as a result of having a full time working partner.

The work/family relationship was very different for male and female consultants in full time/part time families. This type of family structure predominately involved men working full time and women working part time. This family structure was
advantageous to the careers of male consultants but was not advantageous to the careers of female consultants because inequality in occupational status led to greater inequality in the domestic sphere.

The domestic life of female consultants in non traditional family types, (i.e. where the female consultant was the sole breadwinner and her partner cared for their children full time), was not the same as male consultants in traditional family types. Despite both having a partner providing domestic support at home, gender inequality persists. Female consultants in non traditional families were more involved in domestic labour and child care than male consultants in traditional families which restricted women consultants' involvement in their career, but enabled male consultants to have greater freedom to devote to their work.

Gender differences in the work/family relationship were less evident among lone consultant parents. Child care arrangements were a burden for lone consultant fathers and lone consultant mothers. In particular, they experienced difficulty in paying for good quality child care, which could provide cover for unpredictable and long hours, when there was only one earner in the household and no additional child care support available.

Female consultants were more likely than male consultants to be married to or living with another doctor. Marriage to another doctor decreased conflict between work and family roles amongst female consultants because of greater understanding by their partner of a hospital doctor’s lifestyle. However, marriage to another doctor
increased conflict between work and family roles amongst male consultants because of additional pressure on their time, in comparison to their colleagues with non working wives who had greater freedom to devote to their work. Therefore greater equality in occupational status is an advantage for women but for not for men. Three strategies were adopted by dual doctor couples to manage their work and family roles, which involved either, the female consultant accommodating her work role, or reducing family roles by not having children, or work and family roles were highly segregated. The latter seemed the most successful strategy for women consultants in dual doctor couples because it enabled them to have a family life and pursue a full time career. The relationship between family life and the work/family relationship will be discussed in greater detail in chapter eight.
CHAPTER 8

The Gendered Relationship between Paid Work and Unpaid Work

Research has shown that despite increasing numbers of women entering the labour market, inequality persists in the division of domestic labour (Pahl, 1984; Arber and Gilbert, 1992; Gershuny et al, 1994). Among professional men and women, it may be expected that the division of labour in the home would be more equal, however there are indications that women in professional occupations are as likely as women in other occupations to have primary responsibility for organising and undertaking domestic labour (Wajcam, 1996a; Gregson and Lowe, 1993, 1994b). One branch of the academic debate on women’s employment has focused on the association between gender inequality in the labour market and inequality in the domestic division of labour. This chapter will discuss two issues; (i) how does the domestic division of labour in male and female hospital consultant’s households differ and (ii) what is the association between inequality in the domestic sphere and the careers of male and female hospital consultants and why?

8.1. Domestic Labour

Discussion of the division of domestic labour will be used to show that despite reaching consultant grade, female consultants undertake more domestic labour than male consultants and paid domestic labour is more likely to be used to substitute the labour of female consultants to enable them to pursue their career. Male consultants have some involvement with food shopping, cooking, washing dishes and DIY.
However, few male consultants undertake these tasks the majority of the time and they tend to be 'helping' rather than responsible for the overall management of domestic tasks (Table 8.1 and Table 8.2). This compares with female consultants where nearly half (46%) undertake the cooking and laundry (46%) the majority of the time and over half (55%) undertook the food shopping the majority of the time (Table 8.1). Cooking was most likely to be shared equally between partners in female consultants' households (26%) than male consultants' households (15%). Washing dishes was more likely to be shared equally between partners in male consultants' households (41%) than female consultants' households (29%). Slightly more male consultants than the partners of female consultants undertook the food shopping the majority of the time (24% compared to 16%) (Table 8.1 and Table 8.2).

Tasks such as cleaning and ironing are mainly undertaken by paid domestic labour in female consultants' households (Table 8.1). Cleaning was undertaken by paid help in two thirds (71%) of female consultants' households compared to under half of male consultants' households (41%). The majority of ironing was undertaken by paid help in nearly half (49%) of female consultants' households compared to just over a third (36%) in male consultants' households. In male consultants' households, ironing was just as likely to be undertaken by their partners (39%) as by paid help (36%). These differences reflect the higher proportion of male consultants who had non working wives. Tasks were segregated according to traditional gender roles. The majority of laundry was undertaken by female consultants in 46% of households and by male consultants in 10% of households (Table 8.1 and Table 8.2). In contrast the majority of DIY was undertaken by female consultants in only 9% of households and by male
consultants in 64% of households (Table 8.1 and Table 8.2).

Analysis of these data suggests that equality in the domestic division of labour does not exist between partners in the majority of consultants’ households. Instead, female consultants reduce their own involvement in domestic labour by employing paid domestic help, but still undertake a substantial amount of domestic work and retain responsibility for the management of the household.

Table 8.1. Division of household tasks amongst married/cohabiting female consultants with dependant* children (row percentages)

<table>
<thead>
<tr>
<th>Household Task</th>
<th>Majority paid domestic help No. %</th>
<th>Majority Female No. %</th>
<th>Shared Equally No. %</th>
<th>Majority Male No. %</th>
<th>Shared with domestic /paid help No.* No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning</td>
<td>49 (71)</td>
<td>3 (4)</td>
<td>3 (4)</td>
<td>6 (9)</td>
<td>8 (12)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Cooking</td>
<td>0 (0)</td>
<td>32 (46)</td>
<td>18 (26)</td>
<td>6 (9)</td>
<td>13 (19)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Ironing</td>
<td>34 (49)</td>
<td>11 (16)</td>
<td>6 (9)</td>
<td>6 (9)</td>
<td>12 (17)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Laundry</td>
<td>11 (16)</td>
<td>32 (46)</td>
<td>4 (6)</td>
<td>6 (9)</td>
<td>16 (23)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Food Shopping</td>
<td>6 (9)</td>
<td>38 (55)</td>
<td>7 (10)</td>
<td>11 (16)</td>
<td>7 (10)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Washing Dishes</td>
<td>1 (1)</td>
<td>14 (20)</td>
<td>20 (29)</td>
<td>18 (26)</td>
<td>16 (23)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Car Maintenance</td>
<td>49 (71)</td>
<td>1 (1)</td>
<td>2 (3)</td>
<td>12 (17)</td>
<td>5 (7)</td>
<td>69(100)</td>
</tr>
<tr>
<td>Decorating</td>
<td>44 (64)</td>
<td>4 (6)</td>
<td>10 (14)</td>
<td>10 (14)</td>
<td>1 (1)</td>
<td>69(100)</td>
</tr>
<tr>
<td>DIY</td>
<td>15 (22)</td>
<td>6 (9)</td>
<td>5 (7)</td>
<td>42 (61)</td>
<td>1 (1)</td>
<td>69(100)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in the female consultant's home
** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)
Table 8.2. Division of household tasks amongst married/cohabiting male consultants with dependant* children (row percentages)

<table>
<thead>
<tr>
<th>Household Task</th>
<th>Majority domestic/paid help</th>
<th>Majority Female</th>
<th>Shared Equally</th>
<th>Majority Male</th>
<th>Shared with domestic/paid help**</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Cleaning</td>
<td>24</td>
<td>(41)</td>
<td>16</td>
<td>(27)</td>
<td>6</td>
<td>(10)</td>
</tr>
<tr>
<td>Cooking</td>
<td>2</td>
<td>(3)</td>
<td>39</td>
<td>(66)</td>
<td>9</td>
<td>(15)</td>
</tr>
<tr>
<td>Ironing</td>
<td>21</td>
<td>(36)</td>
<td>23</td>
<td>(39)</td>
<td>3</td>
<td>(5)</td>
</tr>
<tr>
<td>Laundry</td>
<td>9</td>
<td>(15)</td>
<td>33</td>
<td>(56)</td>
<td>3</td>
<td>(5)</td>
</tr>
<tr>
<td>Food Shopping</td>
<td>2</td>
<td>(3)</td>
<td>33</td>
<td>(56)</td>
<td>9</td>
<td>(15)</td>
</tr>
<tr>
<td>Washing Dishes</td>
<td>2</td>
<td>(3)</td>
<td>17</td>
<td>(29)</td>
<td>24</td>
<td>(41)</td>
</tr>
<tr>
<td>Car Maintenance</td>
<td>39</td>
<td>(66)</td>
<td>4</td>
<td>(7)</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>Decorating</td>
<td>23</td>
<td>(39)</td>
<td>8</td>
<td>(14)</td>
<td>10</td>
<td>(17)</td>
</tr>
<tr>
<td>DIY</td>
<td>10</td>
<td>(17)</td>
<td>7</td>
<td>(12)</td>
<td>3</td>
<td>(5)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in the consultant’s household
** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)

Among dual career couples with dependant children, domestic tasks were more likely to be shared. Cooking and washing dishes were the two tasks which were most likely to be shared equally between partners in dual career couples (Table 8.3 and Table 8.4). However, even among dual career couples in which both partners worked full time, women or paid domestic help undertook the majority of the domestic labour (Table 8.3 and 8.4). Paid domestic help is employed for cleaning and ironing in the majority of households (Table 8.3 and 8.4). Consequently, female consultants have responsibility for two roles, work and family, compared with male consultants who are more likely to have partners providing domestic support, enabling them greater...
freedom to work.

Table 8.3. Division of household tasks amongst female consultants in dual career couples with dependant* children (row percentages)

<table>
<thead>
<tr>
<th>Household Task</th>
<th>Majority domestic/paid help</th>
<th>Majority Female</th>
<th>Shared Equally</th>
<th>Majority Male</th>
<th>Shared with domestic/paid help**</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Cleaning</td>
<td>35 (74)</td>
<td>2 (4)</td>
<td>2 (4)</td>
<td>3 (6)</td>
<td>5 (11)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Cooking</td>
<td>0 (0)</td>
<td>21 (45)</td>
<td>12 (26)</td>
<td>3 (6)</td>
<td>11 (23)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Ironing</td>
<td>26 (55)</td>
<td>6 (13)</td>
<td>0 (0)</td>
<td>5 (11)</td>
<td>10 (21)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Laundry</td>
<td>11 (23)</td>
<td>18 (38)</td>
<td>3 (6)</td>
<td>4 (9)</td>
<td>11 (23)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Food Shopping</td>
<td>5 (11)</td>
<td>26 (55)</td>
<td>6 (13)</td>
<td>5 (11)</td>
<td>5 (11)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Washing dishes</td>
<td>1 (2)</td>
<td>8 (17)</td>
<td>13 (28)</td>
<td>13 (28)</td>
<td>12 (25)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Car Maintenance</td>
<td>34 (72)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>10 (21)</td>
<td>3 (6)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>Decorating</td>
<td>31 (66)</td>
<td>1 (2)</td>
<td>8 (17)</td>
<td>7 (15)</td>
<td>0 (0)</td>
<td>47 (100)</td>
</tr>
<tr>
<td>DIY</td>
<td>11 (23)</td>
<td>3 (6)</td>
<td>3 (6)</td>
<td>29 (62)</td>
<td>1 (2)</td>
<td>47 (100)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in the consultant's household
** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)
Table 8.4. Division of household tasks amongst male consultants in dual career couples with dependant* children (row percentages)

<table>
<thead>
<tr>
<th>Household Task</th>
<th>Majority domestic/paid help</th>
<th>Majority Female</th>
<th>Shared Equally</th>
<th>Majority Male</th>
<th>Shared with domestic/paid help**</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Cleaning</td>
<td>10 (67)</td>
<td>2 (13)</td>
<td>0 (0)</td>
<td>2 (13)</td>
<td>1 (7)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Cooking</td>
<td>1 (7)</td>
<td>8 (53)</td>
<td>3 (20)</td>
<td>3 (20)</td>
<td>0 (0)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Ironing</td>
<td>6 (40)</td>
<td>3 (20)</td>
<td>0 (0)</td>
<td>2 (13)</td>
<td>4 (27)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Laundry</td>
<td>5 (33)</td>
<td>4 (27)</td>
<td>0 (0)</td>
<td>2 (13)</td>
<td>4 (27)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Food Shopping</td>
<td>2 (13)</td>
<td>6 (40)</td>
<td>1 (7)</td>
<td>6 (40)</td>
<td>0 (0)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Washing dishes</td>
<td>1 (7)</td>
<td>5 (33)</td>
<td>5 (33)</td>
<td>3 (20)</td>
<td>1 (7)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Car Maintenance</td>
<td>11 (73)</td>
<td>1 (7)</td>
<td>0 (0)</td>
<td>3 (20)</td>
<td>0 (0)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Decorating</td>
<td>4 (27)</td>
<td>0 (0)</td>
<td>5 (33)</td>
<td>4 (27)</td>
<td>2 (13)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>DIY</td>
<td>3 (20)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>12 (80)</td>
<td>0 (0)</td>
<td>15 (100)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in the consultant’s household
** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)

8.2. Child Care

Over the past twenty years there has been a steady increase in the number of female doctors pursuing a hospital medical career. As I have discussed in chapter five, the majority of women consultants have children. The following section will examine how women have managed the relationship between their child care responsibilities and their career to achieve consultant grade in Hospital Medicine. Analysis of the data shows that overall, child care was shared more equally between partners than domestic tasks. However, the majority of women consultants use paid domestic help, in the
form of nannies or au pairs and share child care tasks more equally with paid help than with their partners. Over half (55%) of female consultants employed paid child care, in the form of nannies or au pairs, compared with only 20 per cent of male consultants (Table 8.5).

Table 8.5. Primary type of child care used by consultant parents

<table>
<thead>
<tr>
<th>Primary type of childcare</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Parents/relatives</td>
<td>61 (80)</td>
<td>33 (39)</td>
<td>94 (59)</td>
</tr>
<tr>
<td>Paid help in the home (i.e. nanny)</td>
<td>15 (20)</td>
<td>46 (55)</td>
<td>61 (38)</td>
</tr>
<tr>
<td>Paid help outside the home (i.e. childminder)</td>
<td>0 (0)</td>
<td>5 (6)</td>
<td>5 (3)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>84 (100)</td>
<td>160 (100)</td>
</tr>
</tbody>
</table>

Chi-square = 33.02  P>0.001

In female consultants’ households, paid domestic help undertook more child care tasks than in male consultants’ households (Table 8.6 and Table 8.7). Taking children to the nursery was undertaken by paid help in half of female consultants’ households compared to under half of male consultants’ households. Giving children a bath was undertaken by paid help in a quarter of female consultants’ households compared to under a tenth of male consultants’ households. This reflects the greater numbers of male consultants who had non working partners. Although male consultants were involved in child care, their involvement was mainly helping, in terms of providing cover when their partner was not available.
Few aspects of child care were undertaken the majority of the time by men, the only exception being the higher proportion of female consultants’ partners who took their children to the nursery (Table 8.6). However, numbers are small and it is difficult to make any generalisations about this aspect of child care. Getting children up and dressed in the morning was shared more equally between partners in male consultants’ households (55%) than female consultants’ households (42%).

Taking time off work if children were ill was primarily undertaken by women (Table 8.6 and Table 8.7). However, male consultants’ partners were more likely to take time off work than female consultants if their children were ill (54% compared with 33%). This may reflect the different occupations of women in these households, in particular the difficulty for women consultants to take time off work in an emergency. Taking children under five years to the doctors was primarily undertaken by women in both male and female consultants’ households (45% and 63% respectively).
Table 8.6. Division of child care tasks amongst female consultants with dependant* children under five years

<table>
<thead>
<tr>
<th>Child Care Task</th>
<th>Majority domestic/paid help No. %</th>
<th>Majority Female No. %</th>
<th>Shared Equally No. %</th>
<th>Majority Male No. %</th>
<th>Shared with domestic/paid help** No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up and dressed</td>
<td>2 (8)</td>
<td>10 (42)</td>
<td>10 (42)</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Bath</td>
<td>6 (25)</td>
<td>7 (29)</td>
<td>6 (25)</td>
<td>0 (0)</td>
<td>5 (21)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Bed</td>
<td>2 (8)</td>
<td>8 (33)</td>
<td>10 (42)</td>
<td>0 (0)</td>
<td>4 (17)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Time off work if child ill</td>
<td>6 (25)</td>
<td>8 (33)</td>
<td>7 (29)</td>
<td>2 (8)</td>
<td>1 (4)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Takes to doctors</td>
<td>3 (13)</td>
<td>15 (63)</td>
<td>3 (13)</td>
<td>2 (8)</td>
<td>1 (4)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Takes to nursery</td>
<td>6 (50)</td>
<td>1 (8)</td>
<td>1 (8)</td>
<td>3 (25)</td>
<td>1 (8)</td>
<td>12 (100)</td>
</tr>
<tr>
<td>Collects from nursery</td>
<td>6 (55)</td>
<td>1 (9)</td>
<td>0 (0)</td>
<td>2 (18)</td>
<td>2 (18)</td>
<td>11 (100)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in consultant’s household

** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)

Table 8.7. Division of child care tasks amongst male consultants with dependant* children under five years

<table>
<thead>
<tr>
<th>Child Care Task</th>
<th>Majority domestic/paid help No. %</th>
<th>Majority Female No. %</th>
<th>Shared Equally No. %</th>
<th>Majority Male No. %</th>
<th>Shared with domestic/paid help** No. %</th>
<th>Total No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up and dressed</td>
<td>0 (0)</td>
<td>4 (36)</td>
<td>6 (55)</td>
<td>1 (9)</td>
<td>0 (0)</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Bath</td>
<td>1 (9)</td>
<td>3 (27)</td>
<td>5 (45)</td>
<td>0 (0)</td>
<td>2 (18)</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Bed</td>
<td>0 (0)</td>
<td>5 (45)</td>
<td>5 (45)</td>
<td>1 (9)</td>
<td>0 (0)</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Time off work if child ill</td>
<td>1 (9)</td>
<td>6 (54)</td>
<td>3 (27)</td>
<td>1 (9)</td>
<td>0 (0)</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Takes to Doctor</td>
<td>0 (0)</td>
<td>5 (45)</td>
<td>2 (18)</td>
<td>0 (0)</td>
<td>4 (36)</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Takes to nursery</td>
<td>2 (40)</td>
<td>2 (40)</td>
<td>0 (0)</td>
<td>1 (20)</td>
<td>0 (0)</td>
<td>5 (100)</td>
</tr>
<tr>
<td>Collects from nursery</td>
<td>3 (60)</td>
<td>2 (40)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>5 (100)</td>
</tr>
</tbody>
</table>

* dependant children includes children aged 0-16 years living in consultant’s household

** domestic/paid help refers to paid help (i.e. nanny, cleaner) and unpaid domestic (i.e. relatives)

225
Among a minority of female consultants, domestic labour was shared equally between partners, or female consultants’ partners were primarily responsible for child care because they were either not working or were working part time.

"We share domestic responsibilities between us, (my husband) gave me support for the pursuit of my career. He never suggested that his career should come first." 132, female consultant/professor, psychiatry speciality.

full time/part time family

However, in the majority of cases, female consultants had primary responsibility for child care, in particular organisation of child care. The qualitative data suggest that traditional gender roles in the family are closely associated with women’s primary responsibility for organisation of child care. In some cases, responsibility for child care was based on the priority given to each partner’s career. Career priority was based either on best potential income or traditional gender roles in the family. Both were closely linked to the division of traditional family roles in order to sustain family life.

"I’ve taken the burden, in terms of the children, (my husband) has taken the burden in terms of the commuting. This has given us much greater flexibility." 277, female consultant, medical speciality, full time/part time family

"I sort out our nanny who stands in for me, so whenever I need cover, she is
free. (My husband) is free, he knows that when he’s home to see the children, that’s a bonus. He is never responsible for anything unless it’s always been agreed ages ahead." 215, female consultant, surgical speciality, fulltime/part time family

"There was always the assumption that my husband’s career would be first and I would find a part time post to fit in around him, so my career wasn’t really supported by home at all. During the times that I was still training we had young children so he helped out. I think it’s very difficult for both parties to be committed to their career and I think by default the mother has to be flexible." 241, female consultant, anaesthetics, full time/part time family

Some female consultants identified strongly with traditional gender roles as primary carer and considered it their responsibility to organise child care.

"Housework and child care is my responsibility. It is my choice to go to work, therefore my responsibility to cope with it. My husband helps a bit." 185, female consultant, surgical speciality, dual career family

"My son’s care is my responsibility. I get home to take over from the nanny." 014, female consultant, diagnostic speciality, dual career family

Responsibility for child care by female consultants was also undertaken through lack of choice, based on little child care support from their partner.
"Emotionally my husband supports me well, but I am stuck with the care of our child. I have accepted it as part of being a mother, it's my responsibility but sometimes I get fed up with it. So for example if I can't go to an important evening meeting because he's not back from work, I just let it go." female consultant, psychiatry speciality, dual career family

"Now I need him to father the children. He feels that after a busy day, it's nice to go to the gym/play with his motorbike. I would like him to supervise the children...piano practice, homework etc." female consultant medical speciality, dual career family

Having the financial resources to employ good child care was very important in enabling women to work as a consultant in Hospital Medicine. In particular financial resources enabled child care such as nannies, rather than childminders to be employed. This was important because the majority of women consultants' working hours were not structured around a normal working day.

"I couldn't do my job if I didn't have (my nanny). I couldn't take on the sort of responsibilities that I've got here...unpredictability when babies are sick, running your life on depending on other people or trying to get the kids to school. I do an operating list which starts before the children are in school so there is no way I could do my job without it.....one night in three or sometimes more (my husband) and I can be on duty together and in theory we can both be called in at two in the morning and we can't disrupt the children." female consultant, surgical speciality, dual doctor couple

228
8.3. The Gendered Effect of Family Life on a Hospital Career

Having established that the domestic lives of male and female consultants differ considerably, the remainder of this chapter will discuss how the domestic life of male and female consultants has a gendered effect on their professional life. It will aim to show that the 'work role' is different for male and female consultants which is associated with the organisation and management of domestic responsibilities.

Just over half of hospital consultants said their family life had no effect on their career (56%) (Table 8.8). Among consultants who considered their family life had some effect on their career, clear gender differences exist. Male consultants were more likely to consider their family life had been a positive effect on their career (22%), compared with a third of female consultants (31%) who perceived their family life had been a negative effect on their career (P<0.01) (Table 8.8). Male consultant anaesthetists (36%) and obstetricians and gynaecologists (40%) were most likely to consider their family life had a positive effect on their career (Table 8.9). There were few women consultants who considered their family life had a positive effect on their career, however, women consultant obstetrician and gynaecologists were the most likely to consider their family life had a positive effect on their career (33%). In contrast, half the women consultants in the psychiatry (47%) and anaesthetics specialities (50%) and a third (33%) of male consultants in the diagnostic specialities considered their family life had a negative effect on their career. Only 7 per cent of male consultant surgeons considered their family life had a negative effect on their career (Table 8.9).
Table 8.8. Effect of family life on the career of consultant parents

<table>
<thead>
<tr>
<th>Effect of family life on career</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive effect</td>
<td>17 (22)</td>
<td>4 (5)</td>
<td>21 (13)</td>
</tr>
<tr>
<td>No effect</td>
<td>44 (58)</td>
<td>46 (55)</td>
<td>90 (56)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>12 (16)</td>
<td>26 (31)</td>
<td>38 (24)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>3 (4)</td>
<td>8 (9)</td>
<td>11 (7)</td>
</tr>
<tr>
<td>Total</td>
<td>76 (100)</td>
<td>84 (100)</td>
<td>160 (100)</td>
</tr>
</tbody>
</table>

Chi-square=15.16  P<0.01

8.3.1. Effect of Children on Career Progress

In chapter six, I discussed how some female consultants had intentionally delayed childbearing until they completed their higher professional training, in order to benefit their career (Table 6.1). Women consultants who had children at consultant grade were more likely to perceive their family life had no effect on their career, than women consultants who had children during training (62% compared to 51%). However, children were perceived to have had more of a negative effect on the careers of women consultants (30%) than male consultants (16%) (Table 8.10). This occurs amongst women who were 'successful' and it is likely that other women doctors who had children during training may not have achieved consultant grade.
Table 8.9. Effect of family life on career of consultant parents according to specialty group

<table>
<thead>
<tr>
<th>Effect of family life on career</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Effect</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Positive Effect</td>
<td>1 (11)</td>
<td>0 (0)</td>
<td>5 (20)</td>
<td>0 (0)</td>
<td>3 (21)</td>
<td>0 (0)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>No effect</td>
<td>5 (55)</td>
<td>14 (67)</td>
<td>15 (60)</td>
<td>13 (68)</td>
<td>10 (71)</td>
<td>7 (64)</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>3 (33)</td>
<td>7 (33)</td>
<td>4 (18)</td>
<td>4 (21)</td>
<td>1 (7)</td>
<td>2 (18)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (4)</td>
<td>2 (11)</td>
<td>0 (0)</td>
<td>2 (18)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Total</td>
<td>9 (100)</td>
<td>21 (100)</td>
<td>25 (100)</td>
<td>19 (100)</td>
<td>14 (100)</td>
<td>11 (100)</td>
<td>12(100)</td>
</tr>
</tbody>
</table>
Table 8.10. Effect of family life on career according to stage in career when first child was born

<table>
<thead>
<tr>
<th>Effect of career on family life</th>
<th>During training</th>
<th>Consultant Grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Positive effect</td>
<td>14 (24)</td>
<td>4 (8)</td>
<td>3 (19)</td>
</tr>
<tr>
<td>No effect</td>
<td>30 (51)</td>
<td>27 (51)</td>
<td>13 (81)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>12 (20)</td>
<td>16 (30)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>3 (5)</td>
<td>6 (11)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>59 (100)</td>
<td>53 (100)</td>
<td>16 (100)</td>
</tr>
</tbody>
</table>

* Data not available in one case
** Data not available in two cases

Male consultants in traditional family types were most likely to consider their family life had been a positive effect on their career compared with male consultants in dual career families who were least likely to consider their family life had been a positive effect on their career (Table 8.11). The effect of family life on career according to family type for female consultants with dependant children will be discussed later.
Table 8.11. Effect of family life on career according to family type: consultant fathers

<table>
<thead>
<tr>
<th>Effect of family life on career</th>
<th>Dual career</th>
<th>FullTime/Part Time</th>
<th>Traditional</th>
<th>Lone Parent</th>
<th>Single* Person Household/No dependants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive effect</td>
<td>2 (11)</td>
<td>4 (17)</td>
<td>9 (32)</td>
<td>1 (25)</td>
<td>1 (50)</td>
<td>17 (22)</td>
</tr>
<tr>
<td>No effect</td>
<td>13 (68)</td>
<td>13 (57)</td>
<td>14 (50)</td>
<td>3 (75)</td>
<td>1 (50)</td>
<td>44 (58)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>3 (16)</td>
<td>5 (22)</td>
<td>4 (14)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>12 (16)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>19 (100)</td>
<td>23 (100)</td>
<td>28 (100)</td>
<td>4 (100)</td>
<td>2 (100)</td>
<td>76 (100)</td>
</tr>
</tbody>
</table>

* refers to divorced fathers whose children are no longer dependant  
Chi-square=6.07  Not Significant

Four key themes are apparent as to why male consultants considered having a family had been a positive effect on their career. Firstly, being married with children was considered beneficial because it had enabled them to associate with their peer group and to be accepted by their senior colleagues.

"Sometimes there is a perception in consultant interviews, that if you don’t have a family....not settled with a wife and 2.4 children, they may see you outside the mainstream." 078, male consultant medical speciality, dual career family

"As a consultant, family background is important...people wanted to know you are stable. If you have a family it implies a certain amount of qualities you would expect in a consultant colleague." 254, male consultant anaesthetics, traditional family
In comparison being a single male doctor when applying for consultant posts was considered a slight disadvantage to career progress,

"Being unmarried when I applied for consultant jobs was a slight disadvantage. People are not quite sure if you’ll stay." 237, male consultant, obstetrics and gynaecology, traditional family

Secondly, in cases where consultants had a happy family life, children and marriage had been beneficial to their career, because it had provided a supportive environment which had enabled them to cope better with the stresses of their work.

"It has kept me sane and has given me all the physical and emotional support I’ve needed. I would be a very lonely and crotchety old man if it weren’t for my family." 111, male consultant, medical speciality, dual career family

"The family have given me a sense of proportion in terms of the work I am doing now." 153, male consultant, psychiatry speciality, traditional family

"A family is a healthy diversion from the deep well of the NHS which is very easy to fall into." 154, male consultant, psychiatry speciality, dual career family

Similar to consultant mothers, consultant fathers discussed how the experience of being a father benefited their clinical skills.
"Having children has helped me to understand people. I can see how children develop and this has helped me to understand people and their problems." 170, male consultant, psychiatry speciality, traditional family

"I don’t think I could have done my career without the support of the family. Having a family has been a very positive influence both in terms of encouragement and the development of oneself as a person. So wholly positive." 098, male consultant medical speciality, fulltime/part time family

Finally, in a few cases, children had provided motivation to progress and be successful. This was closely linked to association with their traditional role in the family as breadwinner.

"I was supporting my wife and family......so I needed to be a consultant quickly." 147, male consultant, psychiatry speciality, lone parent

"I think that if I had not had (my wife) and a possible family to work for I would have given up at the time when I was unemployed." 235, male consultant, obstetrics and gynaecology, traditional family

Significantly fewer male consultants than female consultants considered marriage and children had a negative effect on their career (Table 8.8). However male consultants who considered their family had been a negative effect on their career stated similar reasons to female consultants. Marriage and children had been negative factors for
male consultants' careers because they had restricted professional activities and increased stress levels. This was experienced by male consultants across all family types.

"Stress and time taken up with problems. I was less available for extra work to further my career." 043, male consultant, diagnostic speciality, traditional family

"I would have chosen more demanding jobs and done more research. Time was spent with the family." 096, male consultant, medical speciality, dual career family

"If I hadn't been married and had a family I would have spent far more hours working and I look at the most successful people and the hours they put in, many work twelve to fourteen hours a day...it's difficult to know how things would have been different but I think I'd have had more time and energy to put into it but then that's the choice you make." 067, male consultant, medical speciality, full time/part time family

Among female consultants, the effect of family life on career varied according to family type (Table 8.12). An opposite pattern emerges compared to male consultants. Female consultants in dual career couples were least likely to consider their family life had been a negative impact on their career (17%). This may partly reflect the slightly greater proportion of female consultants in dual career couples who had their first
child at consultant grade, compared with female consultants in other family types (37% and 23% respectively). However, 57 per cent of female consultants in fulltime/part time families and 50 per cent of female consultants in non traditional family types considered their family life had been a negative effect on their career (Table 8.12).

Table 8.12. Effect of family life on career according to family type: consultant mothers

<table>
<thead>
<tr>
<th>Effect of family life on career</th>
<th>Dual career</th>
<th>Full Time/Part Time</th>
<th>Non Traditional</th>
<th>Lone Parent</th>
<th>Single* Person Household/ No dependants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive effect</td>
<td>1 (2)</td>
<td>1 (5)</td>
<td>1 (12)</td>
<td>1 (20)</td>
<td>0 (0)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>No effect</td>
<td>32 (68)</td>
<td>6 (29)</td>
<td>3 (38)</td>
<td>3 (60)</td>
<td>2 (67)</td>
<td>46 (54)</td>
</tr>
<tr>
<td>Negative effect</td>
<td>8 (17)</td>
<td>12 (57)</td>
<td>4 (50)</td>
<td>1 (20)</td>
<td>1 (33)</td>
<td>26 (31)</td>
</tr>
<tr>
<td>Both positive and negative effect</td>
<td>6 (13)</td>
<td>2 (9)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>8 (10)</td>
</tr>
</tbody>
</table>

Total 47 (100) 21 (100) 8 (100) 5 (100) 3 (100) 84 (100)

* refers to divorced mothers whose children are no longer dependant
Chi-square= 19.74 Not Significant

Among female consultants in non traditional family types, it might be expected that family life would have been a positive effect on their career because the majority of female consultants in non traditional family types had househusbands providing full time domestic support and therefore it might be assumed they would be more similar to male consultants in traditional family types. However, 50 per cent of female
consultants in non-traditional family types compared with 16 per cent of male consultants in traditional family types considered their family life was a negative effect on their career (Table 8.11 and Table 8.12). This analysis shows that female consultants in dual career families experience the least effect of family life on their career. This compares with male consultants in dual career families and in full time/part time couples who experience the most effect of family life on their career. Across all family types, the reasons that female consultants considered their career had a negative effect on their family life was because it had restricted their involvement in extra work activities.

8.4. The Gendered Meaning of Work

Despite achieving career grade status in a male-dominated profession, the majority of female consultants were less involved than the majority of male consultants in extra work activities. This includes aspects of their career relating to national and international work, membership of committees, attendance at conferences, research publications etc. Lower involvement in extra work activities by female consultants was directly related to their responsibilities in their domestic life. It is also related to the structure of these type of activities. Committee meetings, research and teaching preparation are in addition to a normal clinical workload and the majority of this type of work in Hospital Medicine is not structured into the working day but needs to be undertaken in the evenings and weekends.

"When I talk to female consultants in the same situation, they say they do
their research at night and weekends. I can’t, I’ve got my children. Research is not recognised as an integral part of the job. We are expected to publish papers but there is no time in the job."

Extra work activities were compromised amongst women consultants who were managing work and family roles.

"If I had not had a family I would have done more management and got involved in more national committees. I would have had more energy to get involved in a wider sphere which I think I would have enjoyed." 001. female consultant, diagnostic specialty, dual career family.

"If I didn’t have children, I would have stayed in work full time and would have been more involved in my work. I would have written more papers, done more research, looked to work in a teaching hospital. It hasn’t affected my clinical work, but having a family has affected my career." 080. female consultant, medical specialty, full time/part time family

"My academic work has diminished one hundred per cent. My evenings and weekends are taken up by caring for children under five." 185. female consultant, surgical specialty, dual career family
"If I had remained single, I may have been a professor now, I would have had time for research and writing etc." 127, female consultant, diagnostic speciality, dual career family

"A male colleague suggested I came into the breakfast meeting at 7 o’clock bringing my children with me. That was the final straw to be honest.. lack of insight. So, yes, having a family does influence my career." 202, female consultant, surgical speciality, dual career family

The outcome of lower involvement in these extra work activities was restricted opportunity to apply for prestigious jobs in London teaching hospitals, pursue a career in academic medicine and opportunity to gain a distinction award.

"I’m beginning to think having a family has an effect on career progress now but I didn’t five years ago. The reason is that people who have not been a consultant as long as me and haven’t done as much as me are getting distinction awards and I think having a family has disadvantaged me in that respect because I haven’t been able to go to the conferences and regional meetings." 114, female consultant, medical speciality, non traditional family

"Part of me is quite academic and part of me misses the thrust of academic life at London hospitals. If I didn’t have kids I know I would have settled for nothing less than a consultant post at a London teaching hospital and part of me regrets that a little bit, but you can’t have it all and if I had to choose I
would choose the life I have now." 189, female consultant, surgical speciality,
dual career family

8.5. Non Traditional Career Paths

The majority of female consultants had full time continuous career paths similar to male consultants (Figure 8.1 and 8.2). These figures illustrate the small proportion of women who have worked part time and who have become consultants. They also illustrate that virtually no time has been taken out from Medicine, relating to children, amongst women who have become consultants.

A non traditional career path includes consultants who took a career break, and/or had periods of part time work during their training and/or worked part time as a consultant. The remainder of this chapter will discuss the experiences of women who had non traditional career paths in a male dominated profession, yet achieved senior grade.

Nearly a fifth of female consultants trained part time (Table 8.13). Over half (59%) of the consultants who trained part time were working in full time consultant posts. The remainder (41%) were working in part time consultant posts (Table 8.13).
Figure 8.1. Employment status from the end of medical school to 1995
Female Consultants

Figure 8.2. Employment status from the end of medical school to 1995
Male Consultants
Table 8.13. Current employment status of female consultants compared with employment status during training (row percentages)

<table>
<thead>
<tr>
<th>Employment status during training</th>
<th>Currently Full Time</th>
<th>Currently Part Time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Trained Part Time</td>
<td>13 (59)</td>
<td>9 (41)</td>
<td>22 (100)</td>
</tr>
<tr>
<td>Trained Full Time</td>
<td>81 (86)</td>
<td>13 (14)</td>
<td>94 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>94 (81)</td>
<td>22 (19)</td>
<td>116 (100)</td>
</tr>
</tbody>
</table>

Chi-square=7.59  P<0.01

Nearly half (45%) of the women who trained part time were working in the psychiatry specialities (Table 8.14). The least likely speciality for women consultants who trained part time to be working in was obstetrics and gynaecology and the surgical specialities (Table 8.14).
Table 8.14. Current employment status of female consultants compared with employment status during training according to speciality group (row percentages)

<table>
<thead>
<tr>
<th>Speciality Group</th>
<th>Trained Full Time</th>
<th>Trained Part Time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Currently Full time</td>
<td>Currently Part time</td>
<td>Currently Full time</td>
</tr>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>24 (83)</td>
<td>2 (7)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Medical</td>
<td>22 (71)</td>
<td>5 (16)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Surgical</td>
<td>15 (88)</td>
<td>1 (6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>7 (35)</td>
<td>3 (15)</td>
<td>5 (25)</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>6 (67)</td>
<td>2 (22)</td>
<td>1 (11)</td>
</tr>
<tr>
<td>Anaesthesics</td>
<td>6 (60)</td>
<td>1 (10)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Total</td>
<td>80 (69)</td>
<td>14 (12)</td>
<td>13 (11)</td>
</tr>
</tbody>
</table>

Part time consultants were less involved in extra work activities because time was not available due to their greater responsibility for their home life and reduced working hours.

"because I've opted for part time consultant and full time mother, there are things I don't have time to do. By balancing my time to do things I end up concentrating on clinical work and management rather than research and teaching. There are times I would have liked to do research but I realise I don't have the time, I had children instead. So I'm fairly pragmatic." 072, female part time consultant, medical speciality.
The perception that part time training takes twice as long as full time training was not illustrated amongst female consultants who had trained part time. Overall, there was only a two year difference in achieving consultant grade between female consultants who had trained part time compared with those who had trained full time (mean age, 38.7 years and 36.5 years respectively) (Table 8.15). Across the speciality groups, women consultants who had trained part time achieved consultant grade one year later than the average mean age in the diagnostic, medical, psychiatry specialities. Women who had trained part time achieved consultant grade five years later in the surgical specialities and four years later in anaesthetics. In the diagnostic specialities and obstetrics and gynaecology, women who had trained part time achieved consultant grade at an earlier age than men who had trained full time (Table 8.15). However, the very small numbers in some cases make it difficult to draw significant conclusions.
Table 8.15. Mean age achieved consultant grade according to speciality group and employment status during medical training

<table>
<thead>
<tr>
<th>Employment status during medical training</th>
<th>Diagnostic Mean Age (No.)</th>
<th>Medical Mean Age (No.)</th>
<th>Surgical Mean Age (No.)</th>
<th>Psychiatry Mean Age (No.)</th>
<th>Obstetrics and Gynaecology Mean Age (No.)</th>
<th>Anaesthesics Mean Age (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time (men)</td>
<td>37.0 (10)</td>
<td>37.2 (28)</td>
<td>37.2 (15)</td>
<td>38.0 (13)</td>
<td>40.7 (6)</td>
<td>35.7 (14)</td>
</tr>
<tr>
<td>Full time (women)</td>
<td>34.2 (26)</td>
<td>36.9 (27)</td>
<td>36.4 (16)</td>
<td>35.6 (10)</td>
<td>36.9 (8)</td>
<td>34.7 (7)</td>
</tr>
<tr>
<td>Part time (women)</td>
<td>36.3 (3)</td>
<td>38.8 (4)</td>
<td>41.0 (1)</td>
<td>38.9 (10)</td>
<td>38.0 (1)</td>
<td>39.7 (3)</td>
</tr>
<tr>
<td>Total</td>
<td>35.1 (39)</td>
<td>37.2 (59)</td>
<td>36.9 (32)</td>
<td>37.5 (33)</td>
<td>38.4 (15)</td>
<td>35.9 (24)</td>
</tr>
</tbody>
</table>
The majority of female consultants considered their period of part time work had no effect on their subsequent career progress. Three consultants who had trained part time were working in a London teaching hospital and two had achieved high status positions, one was a professor, the other a consultant in a surgical speciality. However, several consultants felt they had achieved consultant status as a part time trainee because they remained in the same speciality, or limited their goals in some way.

"Also partly because of the speciality I’ve chosen, it hasn’t held me up at all."

283. female consultant, psychiatry speciality, part time consultant

"I stayed part time so (part time training) didn’t have a great effect. I had no difficulty getting a post as consultant because I stayed in the same place otherwise you have to be lucky to get what you want." 241. part time female consultant, anaesthetics

"Part time training had no effect because I was realistic to know that I didn’t want a job in a London teaching hospital doing heart bypasses. I wouldn’t have got a job like that." 240. part time female consultant, anaesthetics

"One has to be realistic if one wants to get a full time continuous post in a geographical area was that much worse because of part time training." 274. female consultant, diagnostic speciality
The flexibility offered by part time training was regarded very positively by female consultants who had trained part time. Importantly it had enabled some women to remain working in Medicine, at a time when their family responsibilities may have led to them leaving Medicine. The choice to train part time was made within the constraints of their family life.

"I've appreciated the flexibility in working part time, friends in other professions had to give up... medicine was supportive to me." 140, part time female consultant, psychiatry speciality, trained part time

"I had to move because of my husband’s job and there was no full time vacancy at Bristol, so I would have had to stop, but the part time vacancy became available." 030, full time female consultant, medical speciality, trained part time

Some part time trainees had also benefited from a more tailored training programme.

"It was more tailored to my training, so I was more able to do what I wanted to do rather than what everyone else was doing. I stayed in the same place. I didn’t have to move every six months so I got to know the patients." 132, full time female consultant/professor, psychiatry speciality, trained part time

However, women who had trained part time had experienced negative attitudes towards being a part time worker. Attitudes within Hospital Medicine are highly
ingrained in the association between time spent in work and level of commitment.

"It was hard to go part time because it was looked as a soft option." 168, part
time female consultant, psychiatry speciality, trained part time

"More effort needs to be made to part time working, flexible working. There
is the old difficulty that if you are part time you are part committed and that
is an attitude problem. If you are a mum, you are committed to your children
as well as your work. It doesn’t mean you are less committed, so that attitude
needs changing. Most consultants do private practice, so most consultants
work part time in the NHS, but it simply isn’t perceived as part time, whereas
if it’s less than full time to look after children, it is seen as less than full
time." 277, part time female consultant, trained part time, diagnostic
speciality

"Part time training had an effect on me and my attitude to me, rather than on
other people’s attitude to me, but I always had the feeling from a lot of people
that because I had trained part time, I was not quite pucker. I don’t think it
influenced my progress, because I got a part time consultant job in a
reasonable length of time, but I still felt part time was not the real McCoy." 080, part time female consultant, trained part time, medical speciality

Lack of time for involvement in extra work activities was more acute amongst
consultants who had trained part time. Allocated time during part time hours for extra
work activities was minimal, which reduced opportunity for involvement in extra work activities, such as research. The consequences of this is that part time trainees are likely to have reduced opportunity to achieve a consultant post in a teaching hospital because of less experience in research and teaching.

"I was part time but I was still doing forty to fifty hours anyway. There was never enough time to do research." 274, female district general hospital consultant, diagnostic speciality

"It’s difficult to know if there is a causal relationship between part time training and the impact on my career but part time training did reduce my academic work not my clinical training." 285, female district general hospital consultant, psychiatry speciality

The relationship between work and family life involved two aspects for consultants who trained part time. Part time work enabled time to be divided between two roles, however division of time in this way created conflict for some female consultants during their training years.

"I wanted to work part time because I wanted to split myself between work and the children and ended up feeling I was doing nothing well, not giving enough time to the children because you end up working at home and then off on an afternoon and trying to leave." 080, female consultant, medical speciality, trained part time
In summary, it seems that part time training in Hospital Medicine is both advantageous and disadvantageous to the careers of women consultants. Part time training enables women to remain working in the hospital career structure, when they would otherwise have left Hospital Medicine and offers greater flexibility in terms of moving to new geographical areas with their partners’ jobs. However, part time training had also reduced women doctors’ involvement in extra work activities and had led some women to reduce their career aspirations. Many experienced negative attitudes from their senior colleagues towards being a part time worker and some women who worked part time experienced conflict between their professional and family roles. Analysis of these data suggests that speciality choice benefited women doctors who trained part time. In particular, training part time in psychiatry reduced the potential effect on their career progress because of the greater acceptance of part time work in the psychiatry specialities.

8.6. Summary

Across all family types, domestic labour is not shared equally in male and female consultants’ households. Female consultants are primarily responsible for undertaking or organising domestic labour, even in dual career families, where both partners work full time. Female consultants in dual career couples buy in paid domestic services to help them manage their dual roles. Child care is shared more equally amongst couples where there is a child under five years in the household. However, female consultants have primary responsibility for organisation of child care arrangements. It may be expected that amongst professional women, decisions about child care
would be more equally shared with their partners. However, in many cases, female consultants were solely responsible for organisation of child care. This responsibility for child care is closely associated with traditional gender roles in the family. Half of the consultants considered their family life had an effect on their career development. Male consultants were more likely to consider this a positive effect, in contrast to female consultants who were more likely to consider their family life to be a negative effect on their career.

Inequality in the domestic life of male and female consultants is closely associated with their involvement in their professional life. Despite both male and female consultants achieving consultant grade, female consultants are less involved in extra work activities, such as national work, teaching and membership of committees. This type of work is on top of a normal clinical workload and tends to involve evening and weekend work. Female consultants were less likely to be involved in this type of work than male consultants primarily because of inequality in their domestic life.

The majority of female consultants had full time continuous careers, with virtually no time taken out of Medicine relating to children. Nearly a third of female consultants either currently or at some point had worked part time. Training part time did not have a significant delay in the age consultant grade was achieved across the majority of hospital specialities. Part time working benefited female consultants by enabling them to stay working in Hospital Medicine at a time when their family commitments may have led them to drop out of the career structure. However, many experienced negative attitudes from senior colleagues towards being a part time worker and
because of this some had reduced their career aspirations.

In summary, to achieve consultant grade, the majority of women consultants have worked full time and were heavily dependent upon paid domestic help. However, some women consultants also undertake a considerable amount of domestic labour and organisation of child care themselves. Different family structures have a significant impact in the involvement of men and women in their professional life. Inequality in the domestic life of female consultants and management of two roles did not prevent the women in this study from achieving consultant grade, however it is likely, based on the conflict these female consultants experienced, that conflict between work and family roles have led to many other women dropping out of the career structure.
CHAPTER 9

Speciality Choice and the Relationship between Professional Life and Family Life

Previous research on the careers of women doctors has indicated that women are concentrated in specific hospital medical specialities because of the greater opportunities within these specialities to combine family life and a hospital medical career (Hutt et al, 1981; Ward et al, 1981; Parkhouse and Parkhouse, 1989; Rhodes, 1989; Johnson, 1992; Tait and Platt, 1995). These studies have focused on gender differences between male and female doctors, rather than examining variation between female doctors. Reasons for male and female consultants' final speciality choice will be discussed in the first part of this chapter. The remainder of this chapter will focus on one key question, to what extent is the relationship between professional life and family life managed differently by women consultants in different medical specialities, and why?

9.1. Speciality Choice

Previous literature on the speciality choices made by doctors have shown clear differences between men and women (Parkhouse, 1980, 1991; Allen, 1988, 1994; Parkhouse and Parkhouse, 1989a; Lambert et al, 1996, 1997a). As was expected, similar gender differences existed in the final speciality choice of consultants in the study sample. Consultants were asked why they had chosen their current speciality. Up to four reasons were recorded. The reasons stated were grouped into six areas;
(i) personal interest, (ii) opportunity available at the time (iii) organisational
influences (iv) family influences (v) people/personality influences and (vi) other
reasons. The family influences grouping included; opportunity to combine own
career with partner’s, domestic commitments, consultant’s career looked compatible
with a normal life. The organisational influences grouping included; working hours,
working environment, opportunity to be involved in research work, length of training
and flexibility. Reasons given within the ‘people/personality’ influences grouping
included; role models, family upbringing, encouraged by senior colleagues, speciality
was suited to the consultant’s personality.

Analysis of consultant’s reasons for final speciality choice show that children and
marriage had a greater effect on women consultants’ choice of speciality than male
consultants. Family life influenced speciality choice in two key ways; (i) women
consultants were more likely than male consultants not to choose their preferred
speciality and (ii) both family and organisational influences were a greater factor in
the speciality choice of women consultants than male consultants (Table 9.1).

Speciality choices were more likely to be based on organisational constraints in the
context of family demands for women consultants than male consultants. Some
women consultants had not chosen their preferred speciality because the working
practices and career structure for that speciality were considered incompatible with
a family life. Some choices were made early in training, others were made as a
consequence of conflict between work and family roles, which had resulted in women
changing specialities to accommodate their family roles. This type of conflict was
less evident among male consultants. Women consultants in the diagnostic and obstetrics and gynaecology speciality groups were most likely to state organisational influences as a primary factor in their final choice of speciality (Table 9.2).

Table 9.1. Reasons for final speciality choice amongst hospital consultants

<table>
<thead>
<tr>
<th>Reasons for speciality choice</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Personal Interest</td>
<td>73</td>
<td>(85)</td>
</tr>
<tr>
<td>Organisational Influences</td>
<td>27</td>
<td>(31)</td>
</tr>
<tr>
<td>Family Influences</td>
<td>7</td>
<td>(8)</td>
</tr>
<tr>
<td>Opportunity available</td>
<td>27</td>
<td>(31)</td>
</tr>
<tr>
<td>People/Personality Influences</td>
<td>11</td>
<td>(13)</td>
</tr>
<tr>
<td>Other reason</td>
<td>8</td>
<td>(9)</td>
</tr>
<tr>
<td>Base</td>
<td>(n=86)</td>
<td></td>
</tr>
</tbody>
</table>

NB: Several reasons were given by each consultant therefore the total number of responses is more than 100%. Base numbers have been used for percentages
Table 9.2. Reasons for final speciality choice amongst women consultants according to speciality group

<table>
<thead>
<tr>
<th>Reasons for speciality choice</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Personal Interest</td>
<td>24 (83)</td>
<td>27 (90)</td>
<td>16 (94)</td>
<td>19 (95)</td>
<td>7 (78)</td>
<td>6 (78)</td>
</tr>
<tr>
<td>Organisational Influences</td>
<td>22 (76)</td>
<td>15 (50)</td>
<td>5 (29)</td>
<td>10 (50)</td>
<td>7 (78)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Family Influences</td>
<td>5 (17)</td>
<td>3 (10)</td>
<td>2 (12)</td>
<td>3 (15)</td>
<td>0 (0)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Opportunity available</td>
<td>6 (21)</td>
<td>9 (30)</td>
<td>4 (23)</td>
<td>5 (25)</td>
<td>1 (11)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>People /Personality Influences</td>
<td>1 (3)</td>
<td>3 (9)</td>
<td>2 (12)</td>
<td>1 (5)</td>
<td>0 (0)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Other reason</td>
<td>2 (7)</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Base</td>
<td>(n=29)</td>
<td>(n=30)</td>
<td>(n=17)</td>
<td>(n=20)</td>
<td>(n=9)</td>
<td>(n=10)</td>
</tr>
</tbody>
</table>

NB: Several reasons were given by each consultant therefore the total number of responses is more than 100%. Base numbers have been used for percentages.
Speciality choices made by women consultants in the diagnostic, medical and psychiatry specialties were closely linked to the fit between work and domestic life.

"I chose not do surgery which I had enjoyed because I looked at the senior registrars at the time who were men, they weren't becoming consultants until they were forty, they were doing endless hours in the hospital and I thought if I do wish to have children later on, it's just not going to fit." **014, female consultant, diagnostic specialty**

"There are some specialities I would never even contemplate, for example, paediatrics. You carry on doing mountains of on call all your career. They work horrendously hard even as consultants. I couldn’t cope with doing that and keeping a family going. Some surgical specialities and obstetrics and gynaecology are like that too." **117, female consultant, medical specialty**

"I wanted to do paediatrics but I realised I would be tied to the job by being on call all the time. My husband gave me an ultimatum, paediatrics or him, so I went to do psychiatry. I looked for a speciality that would combine marriage and children." **136, female consultant, psychiatry specialty**

"I didn’t do surgery because of the on call, so I went into medicine and got bored, so I saw dermatology as giving me the opportunity to run a good home life as well and found it an interesting new speciality at the time." **080, female consultant, medical specialty**
Organisational structures and working practices differ within specialities. As expected, anaesthetics, the diagnostic specialities and the psychiatry specialities are perceived to have working practices which are more suitable for combining work and family demands. In comparison, the surgical specialities and obstetrics and gynaecology are perceived to be less suitable for combining work and family roles. The structure of working practices in anaesthetics had enabled women to manage their work and family life. In particular, ongoing patient commitment was an important factor in managing the relationship between work and family life.

"I knew I could do a list, wake up the patients and then go home without having to worry about it. I deliberately picked a speciality where I wouldn’t have continuing care of patients." 252, female consultant, anaesthetics

"It’s a lovely job and when you wake up your last patient, you can go home and plunge into family life." 248, female consultant, anaesthetics

"It became clear to me as I went on that when you’ve finished, you’ve finished. You haven’t got a massive ongoing commitment." 248, female consultant, anaesthetics

In some cases, a speciality was chosen for it’s compatibility with family life. Over time the amount of work involvement required had changed and the chosen speciality was less compatible with a family life as anticipated.
"In radiology, there were a lot of women going into it at the time and it is a misconception that it is a nine to five job. You are in quite a lot of the evenings and weekends now which doesn’t bother me." 014, female consultant, diagnostic speciality

"I thought haematology would fit in with having a family, but the workload and the on call commitment is high so it has not worked out exactly." 118, female consultant, medical speciality

Surprisingly two thirds of women consultant obstetrician and gynaecologists stated organisational influences as a reason for their speciality choice. It seems that obstetrics and gynaecology was chosen in preference to surgery because it enabled women to pursue a career in an acute medical speciality.

"Ideally I’d have liked to do surgery, but general surgery for women is not a good idea. Obstetrics and gynaecology combines surgery and medicine. There’s a quick turnover of patients, deaths are rare. It’s exciting and busy." 222, female consultant, obstetrics and gynaecology

"I didn’t do surgery because there seemed no way in. All the surgical registrar were men and when I qualified, most of the women in my year became anaesthetists, where there was always good opportunity for women, or general practice. I’ve done what I wanted to do but I’ve been swayed by the fact that there were few role models, so I felt the door was closed." 220, female
Women anaesthetists were more likely than any other women consultants to have stated the reason they chose anaesthetics as a career was the opportunities available at the time they were making their decisions. They had chosen this speciality through a number of circumstances, such as working in the speciality as a step towards something else and liked it so they had stayed.

"The career structure of medicine is poor and it would have taken me a long time to become a consultant. There was no sub speciality I was interested in, so I thought I would take a break from medicine. But one area that did interest me was intensive care but I needed to do anaesthetics. So I looked around for a job by the sea with a light on call rota and I took the SHO job in XXXX and my quality of life changed so I stayed." 239, female consultant, anaesthetics

In contrast, decisions about speciality choice made by female surgeons were very different. The majority of women consultant surgeons had decided prior to medical school that they wanted to be a surgeon.

"I intended to do (surgery) from an early age. I could have no concept of what it really involved. I said when I went for my interview at medical school I wanted to do surgery. I think they took it with a pinch of salt." 176, female consultant, surgical speciality
The women consultant surgeons who stated organisational influences as a factor in their final choice of speciality were working within a division of surgery which has more flexible working practices than other surgical specialities and they had chosen this division to accommodate potential family demands.

"I wanted a full time career and time with family. I wouldn't have done general surgery as I don't like blood and guts and also as a woman it's impossible to make it as a general surgeon....there's too many men in it and the hours you have to put in you cannot possibly have a family as well, something has got to give. I wouldn't have been content as a clinical assistant. I want to be at the top but you have to choose the right profession. The career structure in eyes is very suitable for a woman." 189. female consultant, surgical speciality

In summary, similar to previous research findings, women consultants were more likely than male consultants to choose specialities which were considered to be compatible with family life. In particular, the working practices and career structures within specialities were a greater factor in the speciality choice of women consultants than male consultants. As expected, anaesthetics had been chosen for compatibility with family life, which in practice it seemed to have been. However, the working practice in some specialities which had been chosen for their greater compatibility with family life, such as the diagnostic specialities and haematology, had changed over time and were less compatible with family life than expected. Male exclusionary practices were factors deterring women from not choosing surgery, and
some women who would have chosen surgery moved to obstetrics and gynaecology, which enabled them to have a career in an acute hospital speciality. One factor influencing the speciality choice of women consultant surgeons working in ophthalmology, was the greater opportunity to combine surgery with family life in this sub speciality, compared with other surgical specialities. Women consultant surgeons had made decisions about their speciality choice prior to medical school. Firm speciality choice decisions made prior to medical school were less common amongst women in other medical specialities.

9.2. Managing Dual Roles of Work and Family

The 'family type' of consultants varied according to speciality group (see chapter seven). The difference in the domestic lives of male and female consultants is most evident when comparing men and women in the same speciality group (Table 9.3). Gender differences in the domestic life of consultants is most marked in the surgical specialities. Two thirds (65%) of female surgeons were part of a dual career couple, compared with nearly half (47%) of the male surgeons who were part of a traditional family type. Women consultants in the diagnostic specialities were most likely to be part of a dual career couple compared with women consultants in the psychiatry specialities who were most likely to be part of a full time/part time family type.

Women consultants manage the relationship between work and family differently
Table 9.3. Family type according to speciality group

<table>
<thead>
<tr>
<th>Family Type</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Dual Career</td>
<td>4 (40)</td>
<td>18 (62)</td>
<td>9 (32)</td>
<td>12 (39)</td>
<td>2 (13)</td>
<td>11 (65)</td>
<td>3 (23)</td>
</tr>
<tr>
<td>Full time/Part time</td>
<td>3 (30)</td>
<td>3 (10)</td>
<td>11 (39)</td>
<td>6 (19)</td>
<td>5 (33)</td>
<td>3 (18)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Traditional</td>
<td>2 (20)</td>
<td>0 (0)</td>
<td>6 (21)</td>
<td>0 (0)</td>
<td>7 (47)</td>
<td>0 (0)</td>
<td>5 (38)</td>
</tr>
<tr>
<td>Non Traditional</td>
<td>0 (0)</td>
<td>2 (7)</td>
<td>0 (0)</td>
<td>4 (13)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Lone Parent</td>
<td>0 (0)</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (23)</td>
</tr>
<tr>
<td>Single Person</td>
<td>1 (10)</td>
<td>5 (17)</td>
<td>2 (7)</td>
<td>8 (26)</td>
<td>1 (7)</td>
<td>3 (18)</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>10 (100)</td>
<td>29 (100)</td>
<td>28 (100)</td>
<td>31 (100)</td>
<td>15 (100)</td>
<td>17 (100)</td>
<td>13 (100)</td>
</tr>
</tbody>
</table>
across the medical speciality groups (Table 9.4). Women consultants in the psychiatry specialities typically were part of a full time/part time family type, had non traditional career paths, (ie. worked part time and/or took a career break) and combined family life and work during their training years. This compares with women consultants in the diagnostic, surgical and anaesthetics specialities who typically were part of a dual career couple, had a full time continuous career path and combined children with their career during their training years. Women consultants in the medical specialities, typically had a full time continuous career path and were part of a dual career couple. There was no clear typical pattern at the stage in their career at which their first child was born. Women consultant obstetrician and gynaecologists typically had full time continuous career and children were just as likely to be born during training as at consultant grade.

Differences in the relationship between work and family life across the medical specialities are influenced by the characteristics and culture of the speciality. Women in the psychiatry specialities were more likely than women in the surgical specialities to manage their work and family roles by working part time. The culture within psychiatry is favourable towards part time work and is less likely to reduce the opportunities for women to achieve consultant grade. This compares markedly with female surgeons, where part time training was generally considered to be detrimental to career progress. However, part time doctors in the psychiatry specialities may still experience a negative effect of family life on their career.
Table 9.4. Management of work and family roles amongst female consultants according to medical speciality group

<table>
<thead>
<tr>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>24 (83)</td>
<td>19 (61)</td>
<td>13 (76)</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Medical</td>
<td>12 (39)</td>
<td>4 (24)</td>
<td>14 (70)</td>
<td>14 (70)</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>6 (75)</td>
<td>2 (25)</td>
<td>(n=8)</td>
<td>(n=9)</td>
</tr>
<tr>
<td>Non Traditional (i.e. part time/career breaks)</td>
<td>5 (17)</td>
<td>12 (39)</td>
<td>4 (24)</td>
<td>14 (70)</td>
</tr>
<tr>
<td>All</td>
<td>(n=29)</td>
<td>(n=31)</td>
<td>(n=17)</td>
<td>(n=20)</td>
</tr>
<tr>
<td>Stage in career first child was born</td>
<td>15 (71)</td>
<td>10 (53)</td>
<td>7 (64)</td>
<td>12 (71)</td>
</tr>
<tr>
<td>During Training</td>
<td>6 (29)</td>
<td>9 (47)</td>
<td>4 (36)</td>
<td>5 (29)</td>
</tr>
<tr>
<td>Consultant Grade</td>
<td>(n=21)</td>
<td>(n=19)</td>
<td>(n=11)</td>
<td>(n=17)</td>
</tr>
<tr>
<td>Family Type</td>
<td>18 (62)</td>
<td>12 (39)</td>
<td>11 (65)</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Dual Career</td>
<td>3 (10)</td>
<td>6 (19)</td>
<td>3 (18)</td>
<td>9 (45)</td>
</tr>
<tr>
<td>Full Time/Part Time</td>
<td>2 (7)</td>
<td>4 (13)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Non Traditional</td>
<td>1 (3)</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Lone Parent</td>
<td>5 (17)</td>
<td>8 (26)</td>
<td>3 (18)</td>
<td>4 (20)</td>
</tr>
<tr>
<td>Single Person</td>
<td>(n=29)</td>
<td>(n=31)</td>
<td>(n=17)</td>
<td>(n=20)</td>
</tr>
</tbody>
</table>
"Ultimately, I’ve got to where I want to be, a consultant in psychiatry, but maybe it reflects being in a learning disability speciality which is sympathetic to part time training. Other specialities may not have been easy to get back to once left." 140, female consultant, psychiatry speciality

"The work ethic was different (when I trained). If I had tried to make an attempt to work part time, it would have confirmed to my male colleagues that it wasn’t a good idea women doing surgery." 176, female consultant, surgical speciality

9.3. Summary

Women consultants were more likely than male consultants to base their decisions about final speciality choice on the organisational structures within a speciality and its perceived compatibility with a potential family life. These findings support previous studies which have examined the speciality choice of doctors in training (Hutt et al, 1981; Ward et al, 1981). However, there may be an element of post hoc rationalisation in these findings, as with other studies, since these decisions were reliant on memory and made fifteen years previously. Variation across the speciality groups existed, speciality choices made by women consultants in the diagnostic, medical and psychiatry specialities were closely linked to the fit between work and domestic life.

The expectation of a particular speciality being compatible with a family life was
confirmed in anaesthetics but less so in the diagnostic specialities and haematology. Women consultants managed their dual roles of work and family differently in different specialities. In particular, women consultants in the psychiatry specialities were most likely to manage their work and family roles differently to women consultants in other specialities. It seems that different management of work and family roles were influenced by the working practices and structures within specialities.
CHAPTER 10

The Gendered Boundaries between Professional Life and Family Life

The inter-relationship between work and family roles involves a complex interplay between constraints in the domestic and work spheres. The boundaries between professional life and family life vary considerably amongst hospital consultants. This chapter will discuss a typology of the relationship between professional and family life for hospital consultants. This typology comprises three types which I will refer to as; (i) career dominant - work involvement has dominated all aspects of personal life which has affected their ability to develop personal relationships or have children; (ii) segregated - work and family roles are highly segregated, and (iii) accommodating - work involvement has been adjusted to manage and/or benefit family roles. By discussing this typology in the context of male and female consultants and different speciality groups, I will aim to show that the boundary between professional and family life is gendered. Case studies will be used to illustrate the relationship between professional and family life in the context of individual consultants. All names used in the case studies are fictional.

10.1. The Inter-Relationship between the Professional Life and the Family Life of Hospital Consultants

The inter-relationship between professional and family life was significantly different for male and female consultants (P<0.001) (Table 10.1). Two thirds of male consultants and over half of female consultants had a segregated work/family
relationship. However, female consultants were more likely than male consultants to have an *accommodating* work/family relationship or a *career dominant* work/family relationship (Table 10.1).

**Table 10.1. Typology describing the relationship between professional life and family life of hospital consultants**

<table>
<thead>
<tr>
<th>Type of Work/Family Relationship</th>
<th>Male Consultants</th>
<th>Female Consultants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Career Dominant</td>
<td>3 (3)</td>
<td></td>
<td>17 (15)</td>
</tr>
<tr>
<td>Intentional</td>
<td>0</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Unintentional</td>
<td>3</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Segregated</td>
<td>73 (85)</td>
<td></td>
<td>64 (55)</td>
</tr>
<tr>
<td>Accommodating</td>
<td>10 (12)</td>
<td></td>
<td>35 (30)</td>
</tr>
<tr>
<td>Total</td>
<td>86 (100)</td>
<td></td>
<td>116 (100)</td>
</tr>
</tbody>
</table>

Chi-square= 17.34  P<0.001

The levels of integration between professional and family life varied considerably between female consultants in the different medical speciality groups (Table 10.2). Women consultants in the medical and obstetrics and gynaecology speciality groups were most likely to have a *career dominant* work/family relationship. Women consultants in the psychiatry specialities were most likely to have an *accommodating* work/family relationship (Table 10.2). Significant differences were evident between male and female consultants in the psychiatry specialities. The majority of male consultant psychiatrists had a *segregated* work/family relationship compared to over half of the women consultant psychiatrists who had an *accommodating* work/family relationship (P<0.01) (Table 10.2).
<table>
<thead>
<tr>
<th>Type of Work/Family Relationship</th>
<th>Diagnostic</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psychiatry</th>
<th>Obstetrics and Gynaecology</th>
<th>Anaesthetics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Career Dominant</td>
<td>0 (0)</td>
<td>2 (7)</td>
<td>1 (4)</td>
<td>7 (22)</td>
<td>1 (7)</td>
<td>3 (18)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Segregated</td>
<td>9 (90)</td>
<td>22 (76)</td>
<td>24 (86)</td>
<td>15 (48)</td>
<td>13 (85)</td>
<td>4 (20)</td>
<td>6 (100)</td>
</tr>
<tr>
<td>Accommodating</td>
<td>1 (10)</td>
<td>5 (17)</td>
<td>3 (10)</td>
<td>9 (29)</td>
<td>1 (7)</td>
<td>2 (12)</td>
<td>2 (15)</td>
</tr>
<tr>
<td>Total</td>
<td>10 (100)</td>
<td>29 (100)</td>
<td>28 (100)</td>
<td>31 (100)</td>
<td>15 (100)</td>
<td>17 (100)</td>
<td>13 (100)</td>
</tr>
</tbody>
</table>

Table 10.2. Relationship between professional and family life of hospital consultants according to medical speciality.
10.1.1. Career Dominant Work/Family Relationship

Consultants who had a career dominant work/family relationship were primarily single and childless, as a consequence of their professional life dominating all aspects of their personal life, through perceived necessity to achieve consultant grade in Hospital Medicine. This had occurred either intentionally or unintentionally. Divorced consultants who were unintentionally childless because of the demands of their career were also included in this category. There were more women than men in this type (15% and 3% respectively).

The majority (88%, 15 out of 17) of female consultants who had a career dominant work/family relationship were unintentionally single and childless, or what Crompton and Le Feuvre (1996a) refer to as "accidental careerists" (p. 440). Typically in these cases, the professional life of female consultants had dominated all aspects of their life during their twenties and thirties, to the extent that they had been unable to form steady relationships and have children. Two female consultants had also made a conscious choice to forego a family life in preference for their medical career, because they believed achieving consultant grade in Hospital Medicine was not compatible with family life. The constraints of working practices in Hospital Medicine and the pressure to follow a linear career model had strongly influenced the ability of these consultants to develop a family life.

The first case study provides a typical example of a female consultant who made a choice early in her career to remain single and childless. It illustrates how the working
practices within Hospital Medicine were a constraining influence on her choice.

**Case 1: Dr Helen Carr**

Dr Helen Carr is a consultant physician, who is single and childless. She had a full time continuous career path and by remaining childless has been able to devote the majority of her time to her career. She made a choice early in career between Medicine and children believing that it was not possible to combine both and do both well. Experiences of her own mother combining Medicine and children and lack of good female role models were factors in her decision.

"You either had medicine or you had a family and I wasn't going to try and mix the two. My mother tried to mix the two, she was amazingly unhappy with her choice... I didn't see myself with children sending them to boarding school or leaving them with nannies. So it was my bad experience of someone trying to do both and failing as I saw it and seeing no good role models around who were doing it properly, I decided I wasn't going to try. I knew I loved medicine, I didn't know whether I liked children, I thought I probably didn't."

By remaining childless she was able to follow a 'male' pattern of work and conform to the traditional career structure.

"I fitted into the structure rather than trying to force it into anything else.....there wasn't a problem and I don't think I made a mistake in retrospect in the way that the structures of the jobs were in all those years."

The perceived incompatibility of her professional life with a personal life is reflected in her following comments,
"I wouldn't have thought anyone would tolerate me coming in around 8 or 9 pm because it was more interesting for me to finish a paper or something than go home and cook a meal. I organised my life in a way that long working hours didn't matter so much."

Amongst the career dominant women consultants, there were also divorced and childless women, who were childless for reasons relating to their career. Childlessness was not an individual preference but rather the consequences of pressure to maintain a full time continuous career combined with the pressures of a hospital medical career. Case study two provides a typical example of how professional life dominated personal life to the extent that it was difficult to maintain relationships and have children.

**Case 2: Miss Louise Joyce**

Miss Louise Joyce is a consultant surgeon in a London teaching hospital, she is divorced and childless. She devoted a large part of her time to her medical career, working full time throughout her career, with the intention of delaying children until she was established. Her career dominated a large part of her life, because she believed she needed to do this to succeed in Medicine. The consequences were divorce and childlessness. The working practices of Hospital Medicine were an important factor in the breakdown of her marriage, particularly the on call rota which was invasive of her personal time.

"I mentioned that I worked a 1 in 2. We didn't really see that much of one another and I think we failed to address the problem of how we could cope with not seeing one another...having our social life very restricted because half the time I had to say "I'm sorry I can't", and of course it has an effect and I don't think we addressed it."
Maintaining a full time continuous career was a factor in her decision to delay having children.

"As a junior I worked a 1 in 2 every second night living in hospital. You can't have children then. I think you have to make a very frank decision "am I going to have children or am I not?" and the alternative is to say "I'll have a career break". It's quite difficult once you have had the break to get back in and I think my focus at that stage was my career and now having done it that way, I can say perhaps the other way might have been better."

Miss Joyce has strong regrets about the way her career dominated her family life. In an attempt to change the balance between her professional life and family life, she is now reducing her involvement in her professional life.

"Lectures, weekend talks, I purposefully tried to cut down other work outside the twelve hour days. I decided I need a life that isn't medicine, but it is hard because you have worked along a system that expects that and to be actually holding back and just say 'no' is actually quite difficult."

Her regrets about the balance between her professional and family life are also reflected in the way she tries to persuade junior doctors to have more involvement in their family life.

"I say to the juniors "please give time to your home life". It may be that I haven't quite got the balance right because I'm aware I gave too much to medicine and lost out as a result."

Only three per cent of male consultants had a career dominant work/family relationship. Unlike women consultants, male consultants in this type did not seem to make the same choice between family and work. The majority of male consultants
in this type were single and childless because their professional life had dominated their personal life to the extent that they had not formed steady relationships. Case three provides a typical example of a male consultant who had a career dominant work/family relationship.

**Case 3: Dr Tony Lawrence**

Dr Tony Lawrence is a consultant anaesthetist. He is single and childless. He considers his difficulty developing relationships to be largely influenced by the domination of his career over his personal life during his training years,

"The long hours are very damaging, you tend to fall into a routine of work, eat, sleep and you become alienated. You don't see people very often, friendships drift apart, to go out becomes an effort rather than a pleasure and it could be very isolating. I've seen friendships drift apart and again over a number of years you think nothing of it and realise you've not seen friends for over a year and then it's really difficult to pick up."

Dr Lawrence has strong regrets about the domination of his professional life over his personal life during his late twenties and early thirties, which is reflected in the advice he would give to someone considering a medical career,

"Don't do it. The rewards to an individual can be tremendous but at great personal sacrifice in terms of life outside medicine and absorbing more stress than comparable careers. Life as a doctor can be as stressful as a senior manager in industry, it's a lot to ask of twenty five to thirty five year olds. The salary is better in private industry. Sacrificing a lot for high moral principles really. If you are happy with that go ahead,"
In summary, the majority of women who had a career dominant work/family relationship were unintentionally single and childless because their career had dominated their personal life during their twenties and thirties which had led to them being single and childless during their forties. A minority of women in this group had chosen to forego family life in order to benefit their career. The constraints of ‘male’ orientated working practices and pressure to follow a linear career had strongly influenced the ability of women with a career dominant work/family relationship to develop a family life. Organisational constraints had also influenced the personal life of the three male consultants in this group, which had led them to be unintentionally single and childless.

10.1.2. Segregated Work/Family Relationship

Consultants who had a segregated work/family relationship had highly segregated professional and family lives. Eighty five per cent of male consultants and 55 per cent of female consultants had a segregated work/family relationship. The majority of consultants in this category were married/cohabiting with children, although a minority were married childless couples, who were childless for reasons not related to their career. Family roles were organised to enable more time to be devoted to professional life. The majority of women consultants in this category had high levels of paid domestic support to help them with their family roles, and to enable them to
devote a large part of their time to their professional life. The majority of male consultants in this category had a partner providing full time domestic support, or the organisation of their family life enabled them to devote a large part of their time to their professional life. Typically, consultants with a segregated work/family relationship had full time continuous careers. Women consultants in this type were able to follow a more 'masculine' career path, due to responsibility for family roles being reduced, although not as much as for male consultants.

Within this category there was variation between women consultants. Some women consultants were more involved in their family roles than others, in other words, despite having high levels of paid domestic support some women consultants were still responsible for managing their home life. Other women consultants had less responsibility for their home life because it was shared more equally with their partners. However, in both cases women consultants’ family roles were segregated from their professional roles which enabled them to achieve consultant grade in Hospital Medicine. An important factor influencing the relationship between professional and family roles, was the support these women consultants received from relatives and friends to return to work full time after the birth of their first child.

Case four provides an example of a woman consultant who had a segregated work/family relationship, enabling her freedom to pursue a career in an acute speciality in Hospital Medicine.
Case 4: Mrs Miriam Spencer

Mrs Miriam Spencer is a consultant obstetrician and gynaecologist. She has one child aged under five years, who was born during her higher professional training. She is married to a consultant anaesthetist. She has followed a full time continuous career path. Her professional and family roles are segregated by using high levels of paid domestic help to help her manage her family roles. Her attitude towards managing the integration between her family and work roles is evident when she talks about the effect of her career on her family life;

"I've always been a career person. My husband and I are very close and we have good friends and family. But employing someone to nanny and clean, the dogsbody work, this means the time we are off, we spend with our daughter, so we have a very good life and lifestyle."

Although, Mrs Spencer admits that she has always been a career person, an important factor in her returning to work full time after the birth of her son, was her mother's attitude.

"My mother was very encouraging about work, she was desperate when I had James that I should go back to work."

The segregation of her work and family life is also reflected in her attitude towards being married to a hospital doctor.

"We have never worked in the same hospital apart from one and I wouldn't want to. When we've been in the same place, we tried to avoid being over the same operating table, but in an emergency we had to and it was okay, but my working life is one thing and my home life is separate."
Her attitude towards her family role enabled her to manage the segregation between her two roles. Importantly, the knowledge that her child was being well cared for enabled her to remain working full time in Hospital Medicine.

"One of the great sadness is that you can be married, you can be happily married, you can have a family and you can be a consultant and I don't think enough women take that opportunity and that's very sad. When I came back after my daughter, I worried, but you soon get into it. You realise children develop okay if you are not there, providing you spend time with them. I was brought up by a nanny. Women are afraid that if children are brought up by others they will be maladjusted, but it can be done, it's a close run thing."

Case five provides a second example of a woman consultant with a segregated work/family relationship and illustrates how relatives' attitudes were important in managing the boundaries between professional and family roles for women consultants.
Case 5: Dr Jane Hanbury

Dr Jane Hanbury is a full time consultant in the diagnostic specialities. She has two grown up children and is married to a full time general practitioner. She has had a full time continuous career, but has been less involved in extra work activities because of her responsibilities in her family life. Returning to work after the birth of her first child was supported by her husband and his relatives, which was an important factor in her decision to remain in full time employment,

"The most important thing is support of my husband..going back to work after my first child, there was pressure from people, who had stopped working, for me to think hard about going back to work, which was a terrible strain. There was an enormous amount of pressure from people who had decided to give up. If my family and my husband’s family had not been supportive and had said "don’t go back to work", I might have jacked it in, but they assumed I was going to go back to work and leave my child with someone else..... it was expected that I would work if we had children, and expected that we would share household tasks."

Case six provides a typical example of a male consultant who had a segregated work/family relationship which had enabled him to achieve consultant grade in Hospital Medicine. Having domestic support at home enabled him to devote more time to his professional life.

Case 6: Dr Stuart Spalding

Dr Stuart Spalding is a professor of medicine and honorary consultant physician. He is married with two children, who were born during his training years. He has an unbroken employment
history and has had the freedom to develop the academic aspect of his career because of the domestic support he has received from his wife, who is a full time housewife. When talking about the effect his career has had on his family life, he illustrates, through discussion of his working day, how his professional and family roles are segregated.

"One can come home and be preoccupied with the day and therefore the family feel more isolated than the physical adjacency suggests. Preoccupation that if you go home at 10.30 and you’ve been working for fourteen hours then your mind is very full of that. It's very difficult to move worlds. The problem of then going home and your partner has the whole days events which they want to discuss with you."

In summary, the majority of male and female consultants had a segregated work/family relationship. Consultants in this group had highly segregated professional and family lives. Both male and female consultants typically had full time continuous careers and their family life was organised in such a way to enable them to devote a large part of their time to their professional life. In particular, highly segregated work and family roles had enabled women to follow a more 'masculine’ career path which had enabled them to achieve consultant grade in Hospital Medicine.

10.1.3. Accommodating Work/Family Relationship

Consultants who had an accommodating work/family relationship had adjusted their work roles in some way because of their family roles. Only 12 per cent of male consultants and 30 per cent of women consultants had an accommodating work/family relationship. Amongst women consultants, this typically involved a non traditional
career path of career break and/or part time training. Male consultants in this type did not follow a non traditional career path but were more involved in their family life than male consultants who had a segregated work/family relationship, but not to the same extent as women consultants. Male consultants who had an accommodating work/family relationship had reduced their work commitments and after work social activities and/or limited their career goals to spend more time in their family life.

Case seven provides an example of a woman consultant whose work roles changed after completion of her medical training because of her family roles.

**Case 7: Dr Moira Cartwright**

Dr Moria Cartwright is a part time consultant in the diagnostic specialities. She has four school age children and is married to an accountant. She had a full time continuous career until her husband moved country for a new job. Her work and family roles had been segregated until this point, having three children already. She took a career break for four years at consultant grade, which coincided with her husband’s move to England and the birth of her fourth child. Her involvement in her family roles affected her decision to take a four year career break from Medicine,

"I made a conscious decision not to work because of the children. I was pregnant with my fourth child at the time, it would have been complicated to get another job".

Traditional gender roles in the family affected the relationship between her family and professional life,
"My career progression has been dictated by his career. It was the way things worked out. I'm a bit old fashioned, his career comes first because I'm the one likely to be on maternity leave and therefore it is his career which is important."

Dr Cartwright's attitude to her family and work roles affected the type of work/family relationship she adopted.

"I've basically opted out because of the children and my husband's job. The children are probably more of the reason, I should be with them though. I'm happy with my decision. I've had good experience and an exciting job before. If I had not had that I would feel different because I was very career orientated, I was not the person I used to be as I got older and wiser. It's not so important to be career orientated."

Case eight provides a typical example of a male consultant who had accommodated his work roles for his family role, to the extent that his professional life was affected by his involvement in his home life. Unlike women consultants, male consultants in this category typically had full time continuous careers.

Case 8: Dr Dominic Black

Dr Dominic Black is a consultant in the diagnostic specialities in a London teaching hospital. He is married with three children and he has worked full time throughout his career. Dr Black's involvement in his family life affected his involvement in his professional life, particularly in after work hours activities.

"I was meant to go out for drinks after work with others including senior medical staff. I was meant to socialise with the team, but I didn't, as soon as my shift was finished,
I was off, home to my family. There was nothing I could do, my family were important.

Involvement in two roles had also reduced Dr Black's involvement in his professional life.

"I didn't stay at work any longer than I had to, therefore I didn't sit on any committees. In one of my references, it was commented upon that I was loyal to my family and had strong family commitments. Also I was tired when coping with crying babies at night and having to work during the day."

Career progress in Hospital Medicine is strongly influenced by the old boy's network. Dr Black's lower involvement in non working activities could have reduced his ability to develop contacts with senior members of the profession and could have had a potential detrimental effect on his ability to achieve consultant grade.

In summary, women consultants were more likely than male consultants to have an accommodating work/family relationship. This type of relationship involved part time working and/or career breaks for women. Male consultants who had an accommodating work/family relationship had full time continuous careers but were more involved in their family life than male consultants who had a segregated work/family relationship, but not to the same extent as women consultants. Both male and female consultants who had an accommodating work/family relationship had reduced their involvement in their professional life because of their family demands.
10.2. **Attitude towards the Relationship between Professional Life and Family Life**

The majority of male and female consultants had a *segregated* work/family relationship, however, male consultants were more dissatisfied than female consultants about the balance between their work life and their family life (Table 10.3). Satisfaction with the balance between work and family life was greater amongst women consultants who had a *segregated* or an *accommodating* work/family relationship than a *career dominant* work/family relationship. Male consultants who had an *accommodating* work/family relationship were happier about the balance between their work and family life than male consultants who had a *segregated* or a *career dominant* work/family relationship (Table 10.3).

10.2.1. **Career Dominant Work/Family Relationship**

The majority of male and female consultants who had a *career dominant* work/family relationship were dissatisfied with the balance between their professional life and their family life and some were resentful of the way their professional life had dominated their personal life. However, a minority of women and one man were happy with the choice they had made during their twenties and thirties to devote time to their medical career, which had led to them having difficulty developing relationships and consequently were single and childless in their forties. In these cases, the personal satisfaction and achievement they had gained from their professional life had overridden their restricted family life.
"I don't think I had difficulty progressing in medicine but probably its affect on the rest of my life, but that is true for a lot of women who end up in the higher echelons of their speciality. It's not so much if you become a consultant, but if you go further like I have...academic work, national committees..you have your basic jobs and other things. It would be difficult to do that and have a family as well. The sacrifice is in the outside worksphere."

093, female consultant, medical speciality, career dominant

The two women who were intentionally single and childless were happy with their decision to not have a family. Importantly they believed they would not have been able to achieve so much in their career if they had children.

"I would still do medicine and accident and emergency. I have no regrets about not getting married or having a family. You have to be realistic about what you can achieve as a consultant and have children. You can’t be absent on maternity leave because that involves extra managerial issues. Women may need to make choices between children and career, but life is full of choices."

206, female consultant, surgical speciality, career dominant

"I don’t think I made a mistake, in retrospect, in the way that the structures of the jobs were in all those years." 281, female consultant, medical speciality, career dominant

Four women who were unintentionally childless and single were also happy with the
relationship between their professional and family life. Their satisfaction was based on their belief that choices had to be made and that a hospital career was incompatible with family life.

"If I wanted a family I would have done general practice but I didn’t want to. I couldn’t do a hospital speciality and have children...you have to make choices, you can’t have everything." 071 female consultant, medical speciality, career dominant

"I suspect I would make the same decisions, the culture at that time was working all the time, the whole thing was set up for men, who got married to nurses or physios. People spent very little time outside the hospital, that culture is not there any more so probably my life would be different, but not because of the decisions I made but because of external circumstances." 093, female consultant, medical speciality, career dominant

"It just happened that way, it suited me. I don’t have any regrets. You see women working in hospital medicine, it breaks them up, very difficult, children cry, child care falls down. I could not have had a hospital career if I had children, not through choice, but I can’t see how I could have done it. I was able during my twenties and thirties to commit to my career. I didn’t have a househusband which is clearly what one needs.... The way it is structured and the hours that I work is not suitable for a family...twelve hour days." 113, female consultant, diagnostic speciality, career dominant
Table 10.3. Attitude towards own work/family relationship

<table>
<thead>
<tr>
<th>Type of Work/Family Relationship</th>
<th>Career Dominant</th>
<th>Segregated</th>
<th>Accommodating</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
<td>Female No. %</td>
</tr>
<tr>
<td>Regrets/No Choice</td>
<td>2 (67)</td>
<td>7 (41)</td>
<td>37 (51)</td>
<td>8 (13)</td>
</tr>
<tr>
<td>Happy with Balance</td>
<td>1 (33)</td>
<td>5 (29)</td>
<td>25 (34)</td>
<td>47 (73)</td>
</tr>
<tr>
<td>No Comment</td>
<td>0 (0)</td>
<td>5 (29)</td>
<td>11 (15)</td>
<td>9 (14)</td>
</tr>
<tr>
<td>Total</td>
<td>3 (100)</td>
<td>17 (100)</td>
<td>73 (100)</td>
<td>64 (100)</td>
</tr>
</tbody>
</table>
Organisational constraints were an important factor in the domination of professional life over personal life. Women who had a career dominant work/family relationship felt they had no choice but to restrict aspects of their family life, if they wanted a career in Hospital Medicine. However, these women would have preferred it to be different.

"I didn't consciously decide not to have children, but I always felt uneasy about it, I didn't know if there would be retribution. My decision not to have children was a set of circumstances. If I wanted to progress, I had to think about not having children, but there are other reasons not related to the job."

201, female consultant, surgical speciality, career dominant

The remainder of the women and two of the three men who had a career dominant work/family relationship were dissatisfied with the balance between their professional life and their family life.

"You don't have a life outside medicine...where other priorities seem not to weigh up......there is no pot of gold at the end of the rainbow, it's not all it's cracked up to be, there are other ways of living too."

116, female consultant, medical speciality, career dominant

"I wouldn't start my medical career again. I would choose something different. It's taken too much out of me. It's not worth it......I would choose a job that didn't require so much time in the training period. It's twenty years
out of your life and at the end of the day for what? Yes, it’s quite rewarding, but I can think of other things which are quite rewarding as well, that don’t demand as much. We’re not hugely well paid, what you put into it, personally you get very little out of it."

186, female consultant, surgical speciality, career dominant

"I would have a family, I would put more effort into my relationship and my focus would be on personal happiness and personal fulfilment rather than on achievement."

228, female consultant, obstetrics and gynaecology, career dominant

"The rewards to an individual can be tremendous but at great personal sacrifice in terms of life outside medicine and absorbing more stress than comparable careers."

263, male consultant, surgical speciality, career dominant

10.2.2. Accommodating Work/Family Relationship

In comparison with consultants who had a career dominant work/family relationship, consultants who had an accommodating work/family relationship were much happier with the balance between their professional and family life. Although a minority of women felt pulled in both directions and felt they were not doing either job well, the majority of women in this category were satisfied with the balance between their
professional and family life.

"I enjoy being able to combine work with having children, even though it’s exhausting." 30, female consultant, diagnostic speciality, accommodating

"Being a consultant part time, I have time with family and time with work."
168, female consultant, psychiatry speciality, accommodating

"Its been a juggle...to cope you need child care and communication, organisation and planning and energy to enjoy it. You certainly need a lot of energy and you’ve got to want both aspects of life. It’s enhanced my life and I’m where I want to be." 216, female consultant, surgical speciality, accommodating

A minority of women consultants who had an accommodating work/family relationship were frustrated by the balance between their professional and family life because they felt they were doing neither job well.

"Relatively happy, but sometimes I feel as if I am not doing either roles particularly well." 274, female consultant, diagnostic speciality, accommodating

"I made the decision I was going to spend time with the children, rather than be totally devoted to work. There have been times when I have wondered if
this was the right thing to do, perhaps I should have worked full time with a nanny, then you might do one or the other better." **080, female consultant, medical speciality, accommodating**

Some women consultants talked about feeling guilty because they felt they should spend more time with their children, particularly to be available for school events. Male consultants did not talk about feeling guilty in the same way.

"I am not able to be there to watch rugby matches or be there when they get home from school. I feel very sad that I haven’t been more available for them." **012, female consultant, diagnostic speciality, accommodating**

"I won’t be able to be as involved in their school life as other parents are. I have some regrets about it." **161, female consultant, psychiatry speciality, accommodating**

10.2.3. Segregated Work/Family Relationship

The majority of women consultants who had a segregated work/family relationship, were satisfied with the balance between their work and domestic lives.

"I couldn’t spread myself more thinly between work and home. I think I’ve got the level I wish to have as consultant which I can build on and I’ve got a wonderful home life." **220, female consultant, obstetrics and gynaecology**.
"I have an active and fulfilling professional life and I also have a very fulfilling family life." 223, female consultant, obstetrics and gynaecology, segregated

Among a minority of women consultants who had a segregated work/family relationship, one factor influencing their segregated professional and family roles was lack of desire to be a full time mother,

"It's hard to separate things into parcels. I would hate being at home all day. I can't think of anything more drear than meeting the children every day, going home and making them drinks and doing their homework, so I probably wouldn't have been wonderfully good at it anyway." 019, female consultant, diagnostic speciality, segregated

"The children would prefer me to be at home more of the time but I wouldn't. The time spent with them is quality time." 086, female consultant, medical speciality, segregated

"I was torn between work and family. My personality is not suited to being at home all the time, so in the long run I feel my children gained more than they lost." 230, female consultant, obstetrics and gynaecology, segregated
In circumstances where a female consultant was the main wage earner in her household, rationalisation for segregated professional and family roles was based on the need to undertake paid work to provide financial support for her family. This situation had reduced any feelings of guilt she experienced about spending little time with her children.

"I think the main reason that I found it relatively easy to get on and become a consultant was because my husband became a medical student, so there was no question as to whether I was going to work or not because I was the main wage earner."  

"Being a mother and a doctor, I feel more guilty about going to work than (my husband) does, but having invested all that time training, you can’t give it up and one hundred per cent child care would not be for me. My daughter has a disease and so that’s more guilt for me but I have to get on with it.....I’m the main breadwinner."  

The organisation of time was a factor amongst women who had a segregated work/family relationship. There were two key areas; firstly, not enough time to do both jobs well, and secondly little personal time.

"There is not enough time in the day to do both properly, I cut corners at work and I cut corners at home."
"I feel torn in so many directions. There's always so much to do here and so much to do at home, I never feel as if I'm doing anything one hundred percent." 041, female consultant, diagnostic speciality, segregated

"The pressure on my time is so divided up. You have to divide yourself." 057, female consultant, medical speciality, segregated

In contrast, male consultants who had a segregated work/family relationship talked about wanting to spend more time with their family but were unable to because of the constraints of their medical career. In this way, the men who had a segregated work/family relationship were similar to women with a career dominant work/family relationship, who were unable to spend little time on their personal life because of their work commitments. In particular, many of these male consultants felt they had no choice but to work within the demands of Hospital Medicine and limit their time spent in family life if they were to achieve consultant grade.

"I have to spend three evenings a week working until 8pm and sometimes I come in on a Saturday. I'm angry because the system couldn't care less....I've given more to the NHS all my life. I don't want to give any more. It's taken my marriage, I'm not going to let it take everything out of me." 154, male consultant, psychiatry speciality, segregated
"I'm not around as much as I would be if I had another career. My boys have grown up with the situation. If I have not been home I have rung. I would like to spend more time, but medicine takes everything except your soul." 164, male consultant, psychiatry speciality, segregated

"I'd like to spend more time with them, but I spend as much time as I can with them, but it's just a fact of life. It can't really be helped, the work is there to be done, nobody else to do it. Unless I want to give up my current job, which I don't, I have to do what's necessary." 023, male consultant, diagnostic speciality, segregated

"I work ridiculously long hours. I don't think anyone should have to work such long hours, but there doesn't seem to be much choice. That must have a cost, if I don't get home before 8pm at night. With teenage children, it doesn't matter so much, but five or ten years ago I don't think that was right for them. I feel quite angry about it." 166, male consultant/professor, psychiatry speciality, segregated

"I did busy jobs when the children were young so I was not a father to my children because I didn't see them. It made a difference to my relationship with them now, the children are closer to my wife. I would have preferred to be more involved now/then." 096, male consultant, medical speciality, segregated
However, a minority of the male consultants with a segregated work/family relationship were happy with the balance between their professional life and their family life,

"I think it’s probably not too bad, because you are who you are and if I’d sacrificed a lot of my career and done something which I really didn’t want to do, to be there for them, I would be a duller and more irritated person."

219, male consultant, surgical speciality, segregated

Justification for low involvement in family life by male consultants who had a segregated work/family relationship is closely related to traditional gender roles in the family. In particular, low involvement in family life was related to the financial benefits of being a hospital consultant which benefited their family,

"That’s just the way it is really. If I didn’t do this I wouldn’t have the job satisfaction or the standard of living we have now. It would be nicer to have more time for the family."

123, male consultant, medical speciality, segregated

"I’m not there. It’s alright because my family does need some money. It’s a role, people need to go out to work."

026, male consultant, diagnostic speciality, segregated

"I don’t have as much time with them but financially it’s good because we can
send them to private school. There are fewer weekends to spend with the children. It is difficult to plan going away for weekends. An unfortunate necessity, the advantages financially outweigh the disadvantages."

In summary, the majority of female and male consultants with a career dominant work/family relationship were dissatisfied with the balance between their professional life and their family life and some had strong regrets about how their professional life had dominated their personal life. Over half of women consultants who had an accommodating work/family relationship were happy with the balance between their professional and family life, as were the majority of women consultants with a segregated work/family relationship. In contrast, the majority of men with a segregated work/family relationship were dissatisfied with the balance between their work and family life, largely due to the perceived lack of choice, to spend time in family life because of their work commitments.

10.3. Summary

The relationship between professional and family life was significantly different for male and female consultants. The majority of male consultants had a segregated work/family relationship as did the majority of female consultants, but there were more female consultants than male consultants with an accommodating work/family relationship or a career dominant work/family relationship.
Constraints in the occupational structure of Hospital Medicine had influenced the type of work/family relationship adopted by male and female consultants. 'Male' orientated working practices and pressure to have a full time continuous career had strongly influenced the ability of women consultants who had a career dominant work/family relationship to develop relationships and have children during their twenties and thirties. Many of the consultants in this group were dissatisfied with the balance between their work and family life and some had strong regrets about the domination of their career over their personal life.

Both organisational constraints and domestic constraints had influenced the relationship between work and family life adopted by women who had an accommodating work/family relationship. The majority of men and women who had an accommodating work/family relationship were satisfied with the balance between their work and family roles, however women consultants who had an accommodating work/family relationship expressed greater conflict between their two roles than women consultants who had a segregated work/family relationship.

The majority of male and female consultants adopted a segregated work/family relationship. This type of relationship had been adopted by some women consultants because the organisational constraints of Hospital Medicine were perceived to have offered little alternative if they wanted to achieve consultant grade and have a family. A segregated work/family relationship seemed to be the most successful strategy for women consultants, in terms of quality of family life and involvement in professional life. Women consultants who had a segregated work/family relationship were the
most satisfied with the balance between their work and family roles. In contrast, male consultants who had a segregated work/family relationship were the least satisfied, because they felt their choices had been constrained by the demands of the occupational structure, in order to achieve consultant grade.
CHAPTER 11

Conclusions

The analysis of the data on hospital consultants discussed in previous chapters suggests that the relationship between a professional career and family life is closely interconnected, particularly for women consultants. This relationship is important in shaping the pattern of women consultants' careers and is influenced by both domestic and organisational constraints. The work/family relationship is different for male and female consultants and has gendered outcomes, in terms of perceived quality of family life and involvement in professional life. A summary and interpretation of these data in the context of my research questions and the previous research literature will be discussed in this chapter, together with discussion of the implications for policy development in the medical profession. In addition, the theoretical significance of my findings for understanding the pattern of women's careers in a male dominated profession will be explored.

The data on hospital consultants discussed in my thesis are a case study of successful men and women who have achieved consultant grade. The findings are therefore likely to represent the best case scenario and the barriers experienced by women consultants in this thesis are likely to be greater for other women doctors who did not achieve consultant grade. The findings present the experiences of doctors in one geographical area which has greater job opportunity (Fielding and Halford, 1993). Therefore it may be easier for dual career couples in my study to combine two careers with family life. Dual career couples in other parts of the country may experience
greater conflict between their work/family relationship.

11.1. **Explanations for the Pattern of Women Consultants' Careers**

Previous research has shown that women doctors' careers are characterised by over representation in specific hospital specialities and under represented at consultant grade (Allen, 1988, 1994). My research findings on hospital consultants indicate that vertical segregation within the consultant grade exists. My findings will be discussed in terms of three aspects of the structure of women consultants' careers and explanations for these patterns will be explored; (i) the majority of women consultants have full time continuous careers; (ii) women are concentrated in particular specialities and the pattern of women consultants' careers varies by speciality; (iii) vertical segregation exists within the consultant grade.

The majority of women consultants followed a masculine career path, characterised by full time continuous careers with virtually no time taken out of Medicine relating to children. This type of career path is very different from women's employment patterns in other occupations (Brannen et al, 1994; Martin and Roberts, 1980), but similar to women in other professional occupations (McRae, 1991; Glover and Arber, 1995). A traditional career model exists in Hospital Medicine. Women who did not follow this type of career model were considered to be stepping off the career ladder. Only a quarter of women consultants followed non traditional career models and worked part time. They experienced negative attitudes from senior colleagues, which has been shown in previous studies on women doctors (Allen, 1988, 1994).
The majority of women consultants had full time continuous careers because they were constrained by the limited opportunities for part time working and the negative attitudes by senior members of the profession towards part time workers. A quarter of these women said they would have worked part time, if part time opportunities had been available in their chosen speciality and if negative attitudes did not exist. This had resulted in lower involvement in their children’s lives than they would have preferred. Lack of part time opportunities and negative attitudes from senior colleagues towards part time workers, had prevented some women from having children and family life earlier in their career.

The inter-relationship between professional careers and family life was associated with over representation and under representation of women consultants in particular specialities. Previous research has suggested that women consultants are concentrated in specific specialities because of better opportunities within these specialities to combine a career with family life (Parkhouse and Ellin, 1988; Ward et al, 1981; Rhodes, 1989; Tait and Platt, 1995). The empirical evidence in my thesis indicates that women consultants were more likely than male consultants not to be working in their preferred speciality and to have stated that organisational influences, in terms of working hours and perceived compatibility with a family life, were primary factors in choosing their area of medical practice. The majority of male consultants did not experience the same constraints on choosing their area of medical practice. In this way the working practices in Medicine generate sex segregation because women consultants were constrained to work in particular specialities which offered greater flexibility and were thought to be more compatible with a family life. The specialities
which offer greater opportunities for flexible working hours and less emergency on call work are also the less prestigious specialties in Hospital Medicine. As previous research has indicated, anaesthetics and psychiatry were perceived to have working practices more suitable for combining work and family life and these two specialities seemed to have been compatible with family demands. The concentration of women in the diagnostic specialities, has previously been explained by assumed domestic constraints influencing women’s career patterns. However, my findings suggest that in reality the amount of work involvement had changed over time and women consultants in these specialities were spending more of their evenings and weekends in the hospital than they had anticipated when they made their speciality choice.

Organisational constraints were influential in shaping horizontal segregation between specialities. Male exclusionary practices had influenced some women consultant’s choice of speciality, in particular choosing not to have a career in surgery. In some cases, female consultant surgeons had chosen divisions of surgery in which the career structure was more compatible with family demands. Few women considered general surgery to be a viable career option which was related to male exclusionary practices and perceived incompatibility with a life outside Medicine. These findings support Crompton and Le Feuvre’s work (1996b) which suggested that gender segregation in the medical profession is a consequence of choice and constraint (domestic and occupational).

Women consultants managed the relationship between work and family differently across the medical speciality groups. Women consultants in the psychiatry specialities
typically were part of a full time/part time family type and had worked part time at some point during their career and combined family life and work during their training years. Women consultants in the diagnostic, surgical and anaesthetics specialities were typically part of a dual career couple and had full time continuous careers and combined children with their career during their training years. Women consultants in the medical specialities and obstetrics and gynaecology typically had full time continuous career paths and were part of dual career couples and there was no clear typical pattern of the stage in their career at which their first child was born.

A third aspect of the pattern of women consultants' careers is vertical segregation within consultant grade. My findings show that women consultants with children had lower involvement in extra professional activities, such as membership of national and regional committees, than men or women without children. Although women who have achieved consultant grade are "successful" in the sense that they have achieved senior status in their profession, my findings suggest that it is in the area of extra professional activities that gender inequality persists which leads to gender inequality in the higher echelons of the medical profession, i.e. vertical segregation within the consultant grade. The empirical evidence in my thesis suggests that both domestic and occupational constraints are factors associated with women's involvement in extra professional activities.

My findings suggest that lower involvement in professional activities are constrained by inequality in the domestic sphere. The majority of women consultants with children were primarily responsible for the organisation of child care and domestic labour, as
well as undertaking much of this work themselves. In addition, the trend amongst women in professional and managerial occupations to hire paid help with domestic labour and child care (Gregson and Lowe, 1993; Wajcman, 1996a) is shown amongst women consultants. Women doctors are advantaged, like other women professionals, because they have the financial resources to pay for child care. Live in child care arrangements were in some cases the only way women were able to achieve consultant grade, because of the unpredictability of on call work and the need to compete equally with their male colleagues. This is particularly evident in the surgical specialities, where the family structures of men and women are significantly different. Married women surgeons were married to surgeons or other professional men, whereas their male colleagues predominately had non working wives.

Gender inequality exists even amongst women in dual doctor couples and the women with househusbands. Despite having househusbands, these women had greater involvement in managing child care demands than their partners and were therefore less involved in extra professional activities. In contrast, men with housewives were less involved in domestic labour and child care and therefore had greater freedom to work. Maintaining control of family demands is one way that women consultants had managed their work and family roles; others had no choice because of limited involvement from their partner. However managing career and family demands led to reduced professional involvement for some women, and increased stress and exhaustion.

Extra professional activities tend to be structured into a working day, which is not
compatible with child care demands, for example breakfast and late evening meetings. Women consultants with children, spent time outside a normal working day in the second shift, caring for children and family, which constrained their ability to be involved in extra professional activities. The majority of men and women without children did not experience similar constraints. Male and female consultants who were involved in the higher echelons of the medical profession had done so at great personal cost, for women, achievement had led to not having children, for men, it had a detrimental effect on their family life.

Women's involvement in extra professional activities are constrained by occupational structures which set the criteria needed for doctors to achieve this level of professional practice. Career progress to the upper levels of the medical hierarchy, ie. appointments at London teaching hospitals and achieving a distinction award, are associated with involvement in extra professional activities. These criteria have been male defined because they assume time is available outside the working day to undertake these activities. Comparison of the type of work/family relationship adopted with involvement in the upper levels of the medical hierarchy suggests that, there was greater association between type of work/family relationship adopted and type of consultant post held than between achievement of a distinction award and type of work/family relationship (Appendix Seven). Some women consultants with children made compromises in the area of extra professional activities. Analysis of my data suggests this was a compromise made by constraint rather than choice. These constraints exist amongst women who have achieved consultant grade and are therefore likely to be greater amongst women who did not achieve consultant grade.
11.2. Types of Work/Family Relationship

The professional life and family life of hospital consultants is closely interconnected and is influential in shaping their career paths. This is more evident for women consultants than male consultants. Three types of work/family relationship were identified amongst hospital consultants which had been adopted to manage the relationship between their work and family life. The majority of male and female consultants had 'segregated' work/family relationships, although women were more likely than men to have a 'career dominant' or an 'accommodating' work/family relationships. The greater likelihood for women than men to have 'career dominant' or an 'accommodating' work/family relationship was associated with domestic and organisational constraints.

Women consultants who had 'career dominant' work/family relationships (about a fifth of women) had intentionally or unintentionally allowed their careers to dominate their personal lives to the extent that they had remained single and childless. Remaining single and childless was closely associated with the constraints their career had on their personal life, in terms of long working hours during their twenties and thirties, frequent geographical moves, which had in some cases led to the break up of stable relationships. Intentionally remaining single and childless was associated with constraints within the occupational structure of Hospital Medicine, in particular, to have a linear career and follow "masculine" ways of working in order to achieve consultant grade, which they did not perceive to be compatible with having children and a family life. The women in this group were not constrained by their domestic
life and lack of these constraints were considered important in enabling them to achieve consultant grade and, in some cases, be involved in the upper levels of the medical hierarchy.

A third of women had adopted an 'accommodating' work/family relationship. These women had typically worked part time or taken a career break during their training to care for children. However, women's career choices in this group had been constrained both by domestic and organisational constraints. Adopting an 'accommodating' strategy for many women consultants had a double edged sword. Part time work had enabled women to manage their family demands and still achieve consultant grade, at a time when they may have dropped out of the hospital career structure, but working part time had restricted their career options.

In hospital medical culture, part time work is negatively associated with lower commitment to paid work and part time opportunities are limited in prestigious specialities. The majority of women who trained part time compromised their career goals in some way. However, a minority of women in this group had not limited their career goals, notably two women had achieved senior status in Hospital Medicine, both had achieved consultant posts in London teaching hospitals, one as a professor in academic medicine, the other as a consultant in surgery. However, for the majority of women consultants who had trained part time, the "practitioner" option (Crompton and Sanderson, 1990a) had led to women not achieving their full potential in their working lives. Training part time in the psychiatry specialities had less of an effect on career progress than part time work in other specialities because of the more positive
attitudes towards part time workers in psychiatry.

The majority of male and female consultants had adopted a 'segregated' work/family relationship, where family roles and work roles were highly segregated. A 'segregated' work/family relationship had been adopted by some women consultants because the organisational constraints were perceived to have offered little alternative if they wanted to achieve consultant grade and have a family.

Johnson and Johnson's work (1992) on dual doctor couples in the United Kingdom suggests that male doctors in dual doctor couples have career priority and women doctors were more likely to follow their husbands to new geographical areas for their partner's career. Evidence of this was found in some cases in my study, which I have referred to as doctors who adopted an "accommodating" strategy, however there was also evidence of dual doctor couples who had "childfree" or "segregation" strategies. These women doctors had not followed their husbands careers, and equal priority had been given to both partners' careers. The "childfree" strategy had led women to not having children and the "segregation" strategy had led to the work and family roles of women consultants being highly segregated. The latter seemed to be the most successful strategy.

11.3. Gendered Outcomes of the Work/Family Relationship

Different types of work/family relationship had a gendered outcome for the careers and family life of consultants, in terms of their level of involvement in their career and the
perceived quality of their family life. Male consultants who adopted an 'accommodating' work/family relationship had similar career and family life outcomes to women who adopted a 'segregated' work/family relationship.

My analysis shows that women who adopted a 'segregated' work/family relationship were the most satisfied with the balance between their work and family roles. In contrast men who had a 'segregated' work family relationship were least satisfied because they felt their choices had been constrained by the demands of the occupational structure, in order to achieve consultant grade. Some men in this group were angry about the detrimental effect their career had on their family life, in terms of strains in marital relationships and little involvement in their children's lives.

The majority of women with an accommodating work/family relationship were also satisfied, although greater conflict was experienced between managing work and family roles. Only a minority of women who had a career dominant work/family relationship were satisfied with the interface between their work and family life. The majority of men and women with a career dominant work/family relationship had strong regrets about how their career had dominated other aspects of their life. This was closely associated with the way male dominated working practices and career structures had led to their career dominating other aspects of their life.

The inter-relationship between professional careers and family life had a gendered outcome in terms of perceived quality of family life for consultants in different family structures. Consultants in different family structures varied in their perceptions about
the effect their family life had on their careers. Women in dual career families perceived their family life had the least negative effect on their careers, compared with women in non traditional and part time/full time families who perceived their family life had the greatest negative effect on their career. The opposite pattern existed for men. Male consultants in dual career families perceived their family life had the greatest negative effect on their career, compared with men in traditional or full time/part time families who perceived their family life had the least negative effect on their career. This suggests that greater equality in employment was an advantage to women but not to men. Allen's studies (1988, 1994) have shown an increasing trend for younger male doctors to be in dual career or dual earner families. Therefore this conflict is likely to increase amongst future generations of male hospital doctors.

Currently attitudes and practices in Hospital Medicine are based on traditional models of the typical worker being male and the primary wage earner. This traditional culture no longer reflects the typical doctor, who is likely be part of a dual career, or dual earner couple, and increasingly likely to be female. The negative effect of a hospital career on family life, as experienced by half of the male and female consultants in my study, is likely to increase rather than decrease with younger cohorts of doctors and among future consultants. It is likely that the conflict between work and family which has affected the life of female doctors is increasingly going to affect the lives of male doctors.

The relationship between professional careers and family life is closely interconnected particularly for women consultants. This relationship had a different outcome on the
family building patterns of women compared with men. The family building patterns of women consultants, like other women in male dominated professions, were constrained by male orientated working practices and the organisational culture within the medical profession. Women consultants were more likely to be single, less likely to have children, and have their children at a later stage in their career than male consultants. This reflects findings from other studies of women doctors in the United Kingdom (Allen, 1988, 1994; Tait and Plait, 1995) and is similar to other professional women in male dominated professions (Silverstone and Ward, 1980; Wajcman, 1996a, 1996b). In particular, many women delayed having children until they had finished training, either intentionally or unintentionally, because of concern that children would have a negative effect on their career progress. Pressure to follow a linear career path and lack of satisfactory part time opportunities had constrained women doctors decisions when to have children, if at all.

The conflict experienced in the timing of childbearing was greater amongst women consultants than male consultants. Women who had children during training perceived that their family life had a negative effect on their career progression, which was not the case for women who had children at consultant grade. Most women consultants who had children had taken only very short periods of maternity leave, or had been available for work during their maternity leave. Taking maternity leave was perceived to be a nuisance by their senior colleagues, rather than a statutory right.

Women consultants had managed their maternity leave arrangements in a number of ways but all had been managed at the individual level. The gendered nature of
organisational cultures has been discussed in previous research literature (Hearn and Parkin, 1987; Acker, 1990; Cockburn, 1991; Savage and Witz, 1992) and a similar gendered organisational culture exists in Hospital Medicine. Organisational structures have been defined by men in Hospital Medicine which is reflected in the lack of organisational provision for maternity leave. Women consultants had managed to combine childbearing with the demands of their career but it had created additional pressure and stress in their personal life. It is likely that other women doctors would have dropped out of the hospital career structure at this stage.

Women consultants in this study trained at a time when the majority of doctors were male. Women doctors adopted strategies to ensure that minimal disruption occurred to their department as a result of them becoming mothers, which reflects the pressure women felt to compete equally with men. This type of strategy has been found amongst other studies of professional women (Lewis and Cooper, 1989). Current changes to specialist medical training (Department of Health, 1993) are likely to increase the numbers of women who delay having children until training is completed, therefore the demand for maternity leave at consultant level is likely to increase in the future.

A hospital career was perceived to have had a negative effect on the family life of half of the male and female consultants interviewed. Frequent geographical moves during training was detrimental to the stability of family life and the unpredictability of on call hours, combined with long working hours had limited the involvement both men and women had in their family life. Some of the consultants interviewed wanted a
career structure which benefited the family and personal life of doctors. The notion that Medicine is a caring profession conflicts with the demands made of doctors in training and increasingly at consultant grade, because most who are successful sacrifice other aspects of their life for their work.

Similar to other male dominated professions, the male organisational culture in Hospital Medicine reflects the values and assumptions of men. These assumptions are based on greater value given to workers who do not let their family life intrude on their working life (Lewis, 1991). However these assumptions and values were embedded in the medical profession at a time when the majority of doctors were male and had non working wives providing domestic support at home, enabling them greater freedom to work. The majority of women consultants had to work within these norms and assumptions in order to have successful careers in Hospital Medicine, which created conflict. There was also evidence of some male doctors experiencing conflict between what was expected of them if they were to succeed in Hospital Medicine and their own preferences for a more balanced relationship between their career and family life.

The process of achieving consultant grade had a greater negative effect on forming stable personal relationships for women than men. This was associated with the intensity of the training period required during their twenties and thirties. Some of these women, together with women who had not had children because they wanted to achieve consultant grade, had regrets about the domination of their career over their personal life. The careers of these women doctors had been uni-dimensional, which
had enabled them to have successful careers in Hospital Medicine. However, the personal cost for some had been too great, particularly when linked to their current increasing job dissatisfaction at consultant grade.

11.4. A Change in Hospital Medical Culture and Discourses of Time

Feminist sociologists (Itzin and Newman, 1995; Rubin, 1997; Liff and Cameron, 1997; Lewis, 1997) have recently argued for a shift away from equal opportunities policies which focus on women and changing working practices to benefit women’s assumed domestic constraints, towards a shift in culture, attitude and practices which recognise that both men and women have families and need time for personal and family life. The empirical evidence in this study suggests that this process needs to take place in Hospital Medicine. There has been a particular focus in research studies (Allen, 1988, 1994) and in medical planning policy on providing better part time training opportunities in Hospital Medicine. The findings from my study suggest that part time training is important in enabling women to remain working in Medicine and achieve consultant grade, however they also show that negative attitudes by senior members of the profession towards part time work disadvantaged part time workers.

A change in these attitudes is only likely to occur if a substantial number of male doctors train part time, however this is unlikely while organisational discourses of time are associated with a full time career path as a sign of commitment. The macho culture in Medicine, particularly within the surgical specialities, does not help in aiding this process. In addition, my findings suggest that part time working is not the best
option for women doctors in Hospital Medicine. Part time work led to career goals being limited and women taking on a greater role in domestic work which increased gender inequality in the domestic sphere and led to increased problems for women in trying to combine their dual roles.

An alternative direction would be for a change in the culture, attitudes and practices in Hospital Medicine which benefits all doctors, not just women. There is a need to shift away from providing services which enable women to remain in Medicine, towards structures which enable men and women to be more involved in their family life and recognise that male doctors are either neglecting their families or are under considerable pressure and stress. Recent changes which have reduced juniors working hours (Department Of Health, 1991) and in the length of specialist medical training (Department Of Health, 1993) are progress towards this change but organisational discourses of time and attitudes towards personal and family time still prevail.

A change in the organisational discourses of time in Hospital Medicine would benefit all doctors. Organisational discourses of time in Hospital Medicine are associated with time spent in the hospital as representing commitment, which is detrimental to the family life of male consultants and is associated with vertical segregation in the consultant grade. Directions for change include a shift in attitudes which recognises flexibility and diversity in career paths and other aspects of doctors lives, without non traditional ways of working being seen as detrimental to career progress. In addition, working practices, which include part time working, more flexibility in full time hours, the structuring of meetings into working days rather than early evening meetings and
breakfast meetings, training of juniors organised into week days rather than on Saturdays and fewer medical meetings on a Friday evening would enable doctors to spend more time on their personal and family life.

The conclusions that can be drawn from my thesis have policy implications for the medical profession. There has been increasing concern about the number of doctors leaving Hospital Medicine, both at a junior level and at consultant grade (Allen, 1994; Royal College of Physicians, 1996; Lambert et al, 1997). Exodus from Hospital Medicine has resulted from increasing job dissatisfaction, less autonomy and a general low morale amongst hospital doctors. A career in Medicine has historically been associated with having a vocation, where limited personal or family life was perhaps more acceptable. Empirical evidence in my thesis shows dissatisfaction with the personal cost and sacrifice that some consultants had made for their hospital career, even amongst doctors who trained at a time when Medicine was more of a vocation.

Current doctors in training are showing dissatisfaction with working hours and on call commitments and wish to spend more time in family and personal life. As Medicine becomes less of a vocation, and less job satisfaction exists, the compromises and sacrifices made to personal life may no longer be acceptable to hospital doctors and they may choose other career paths. Changes need to be made to the organisational culture and attitude within the medical profession which will recognise the need for doctors in training and at consultant grade to have time for personal and family life. Findings from my thesis suggest these changes are important if Hospital Medicine is to continue to be an attractive career option for doctors in the future.
11.5. **Study Limitations and Further Research**

My thesis has several limitations. Firstly, there was little detailed information collected on the involvement of doctors in professional activities such as, the Royal Colleges, teaching, membership of national and international committees. Data on conference presentations, research publications, involvement in the Royal Colleges, amount of private practice work, posts held on national and regional medical committees, and information on posts held in local trusts (i.e. clinical director) would have provided a more detailed analysis of gender differences in consultants' involvement in extra professional activities. It is likely that this information would have provided greater strength to the findings from the qualitative data, which showed that women with children were less involved in these activities than men or women without children. It would have been interesting to have examined differences in extra professional activities between consultants in different speciality groups, which was not possible based on the information collected.

Secondly, my thesis could be criticised because it focused on successful doctors and omitted men and women who had not achieved consultant grade. In addition, it only focused on consultants aged forty to fifty years whose experiences of medical training are different from current doctors in training, in particular a shorter career structure and shorter working hours. However, my findings show the detrimental effect that frequent geographical migration and long working hours had on family life, which is important in reiterating the need to change previous training structures and to ensure that shorter working hours and rotational training schemes are maintained in the future.
Consultants aged forty to fifty years were selected because data would be available for the peak years of childbearing and career development. In retrospect, I think this choice of age group was beneficial to my analysis because the data available were provided for consultants over the whole span of their professional and family life. In addition, a substantial number of women had delayed having children until they were consultants and a high proportion had children under five years of age. Information on managing work and family roles would not have been available for many doctors if I had chosen a younger cohort of doctors.

My thesis only includes consultants in one particular geographical area. This may be a limitation to the study because the area of study included greater job opportunity in this geographical area and also increased possibility for commuting between London and areas of the South East of England. The experiences of consultants in this study will therefore represent a best case scenario, and the conflict between professional life and family life amongst consultants in other areas of the country may be greater.

**Future Research**

In the context of these limitations, future research on the inter-relationship between professional and family life of male and female consultants would benefit from a more detailed analysis of the differences between medical specialities, using a qualitative methodology. Specialist medical training is currently being introduced and reduced junior doctors' hours have only been in practice for six years. Therefore the effects
of these changes on the inter-relationship between work and family life of doctors who achieve consultant grade in the future will not be known for many years.


AIRD LA, SILVER PH. "Women doctors from the Middlesex Hospital Medical School 1946-67." British Journal of Medical Education 1971;5:232.


ASHLEY-MILLER M, LEHMAN M. "Alternative career paths for doctors: Is the NHS facing up to its responsibilities as an employer?" British Medical Journal 1993;307:886.


324


BRUEGEL I. "Whose myths are they anyway?: a comment." British Journal of Sociology 1996b;47:1:175-7.


CLARK L. "Just how far have women doctors come?". Medical Economics 1991a;48-58.

CLARK L. "For women doctors the road is still bumpy". Medical Economics 1991b;16:61-71.


CORTI L, DEX S. "Highly qualified women" Employment Gazette March 1995a;115-121.


DALE A. "Occupational Inequality, Gender and Life-Cycle". Work, Employment and Society 1987;327-350.


DALE A, GLOVER J. (1987) A comparative analysis of Women's Employment Patterns in the UK, France and the USA. Department of Sociology, University of Surrey.


DILLNER L. "Why are there not more women consultants?" British Medical Journal 1993;307(6910):949-950.


DUMELOW C, GRIFFITHS S. "We all need a good wife to support us" Journal of Management in Medicine 1995;9:1:50-57.

ELLIOT FR. "Professional and Family Conflicts in Hospital Medicine". Social Science and Medicine 1979;13A:57-64.


GLASS-CROME I, CROME P. "Both men and women need family lives" British Medical Journal 1993;307:1285. (letter)


GODLEE F. "Stress in women doctors" British Medical Journal 1990;301:


333
GREGSON N, LOWE M (1994a) Servicing the Middle Classes. London: Routledge

GREGSON N, LOWE M. "Waged domestic labour and the renegotiation of the domestic division of labour within dual career households". Sociology 1994b;28:1:55-78.


HAKIM C. "Grateful slaves or self made women: fact and fantasy in women's work orientations". European Sociological Review 1991;7:101-121


JOSHI H. "Women's participation in paid work: further analysis of the women and employment Survey". Department of Employment Research Paper 1984; No.45.


LEVINSON W. "Work may be good medicine". *The Lancet* 1995;345:140-141.


LUNN JE. "A survey of Sheffield medical women graduating over the years 1930-1952". Medical Care 1964;2:197.


MACEWEN KE, BARLING J. "Daily consequences of work interference with family and family interference with work". Work and Stress 1994;8:244-54.


MADDOCK S, PARKIN D (1994) Barriers to Women Hospital Doctors. Manchester: North West Regional Health Authority.


PARKHOUSE J. "A follow-up of career preferences". Medical Education 1976;10:480-482.


RICHARDS T. "Disillusioned doctors need a better balance between service commitment and education" British Medical Journal 1997;314:1705-1706.

RICHARDS P, MCMANUS C, ALLEN I. "British doctors are not disappearing but career patterns are changing". British Medical Journal 1997;314:1567.


ROSS CE. "The Division of Labour at Home". Social Forces 1987;65:3:816-833.


SAYER J. "Applying for flexible training". British Medical Journal 1995;311:1025 (Letter)


SMITH J. "Consultants of the future: Need to acknowledge organisational goals and play to their strengths". British Medical Journal 1995;310:953-954.


STANLEY GR, LAST JM. "Careers of young medical women." British Journal of Medical Education 1968;2:204.


STREETLY A. "Women consultants and merit awards". British Medical Journal 1994;308(6945);1712 (letter)


SULLIVAN P. "Women close in on 50% of places in Canada's medical schools". Canadian Medical Association Journal 1990;143:8:781-783.


ULYATT K, ULYATT FM. "Attitudes of women medical students compared with those of women doctors". British Journal of Medical Education 1973;7:152.


WALTERS BC. "Why don't more women choose surgery as a career?" Academic Medicine 1993;68:5:350-351.


INTERVIEW GUIDE - QUALITATIVE INTERVIEWS

ID ____________

SEX Male
   Female

GRADE ______________

SPECIALITY ____________

GENERAL QUESTIONS

Marital Status
Children- number and age
Employment status
Grade in career married/divorced

MEDICAL TRAINING

Employment status during training
employment status since consultant
periods of work abroad
periods of unemployment
Effect of type of training on subsequent career progress
Choice of speciality at end of medical school
Reasons for speciality choice
Reasons for speciality change (if relevant)
Personal ambitions on leaving medical school

APPENDIX ONE
FAMILY LIFE

Grade in career married/began cohabiting
Partner’s occupation
Partner’s employment status
Partner’s attitude towards your career
Effect of marriage on own career progression
Grade first child was born
Child care
Domestic support
Effect of children on career progression
Main issues, relating to family life which benefit or constrain your career

ORGANISATIONAL

At medical school were you discouraged from a particular type of career in medicine or a particular speciality?
Help from senior colleagues in furthering career
Main issues, relating to professional life which benefit or constrain your career
Attitude of senior colleagues towards women doctors (During medical school, during postgraduate training)

ACHIEVEMENT

What has been the biggest constraint on your career progress? Why?
What has been the biggest aid for your career progress? Why?
Are you happy with your achievement in your medical career so far? Why?
INTERVIEW SCHEDULE

<table>
<thead>
<tr>
<th>ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>MALE 1</td>
</tr>
<tr>
<td></td>
<td>FEMALE 2</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job Title:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSULTANT</td>
<td>1</td>
</tr>
<tr>
<td>ASSOCIATE SPECIALIST</td>
<td>2</td>
</tr>
<tr>
<td>STAFF GRADE</td>
<td>3</td>
</tr>
<tr>
<td>CLINICAL ASSISTANT</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speciality:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC</td>
<td>1</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>2</td>
</tr>
<tr>
<td>SURGICAL</td>
<td>3</td>
</tr>
<tr>
<td>PSYCHIATRY</td>
<td>4</td>
</tr>
<tr>
<td>OBSTetrics AND GYNEACOLOGY</td>
<td>5</td>
</tr>
<tr>
<td>ANAESTHETICS</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTH LONDON</td>
<td>1</td>
</tr>
<tr>
<td>SURREY</td>
<td>2</td>
</tr>
<tr>
<td>SUSSEX</td>
<td>3</td>
</tr>
<tr>
<td>KENT</td>
<td>4</td>
</tr>
</tbody>
</table>

Age became consultant: _____

APPENDIX TWO
SECTION A - WORK HISTORY

would like to start by asking you some questions about your work history.

1. Are you currently working full time or less than full time in hospital medicine?
   - Full time .........................................................1
   - Less than full time ............................................2

2. When you were a junior doctor did you at any time train part time?
   - Yes ...........................................................................1
   - No (GO TO Q46) ....................................................2

X DOCTORS WHO HAVE TRAINED PART TIME:

1. Did you have any particular reason for training part time? (Circle Yes or No for each category)

   Yes No
   - Caring for children .............................................1 2
   - Caring for elderly relatives .................................1 2
   - Caring for sick relatives ....................................1 2
   - Personal illness ..................................................1 2
   - Other reason(SPECIFY) .......................................1 2

State other reason


1. When you returned to work full time in medicine, were you able to find a job in the same speciality?
   - Yes ..(Ask A) ..........................................................1
   - No ..(Ask A) ..........................................................2
   - Yes, stayed in same job ..(Ask A) ............................3
   - No, wanted to change specialities(Ask A) ...............4
   - Not applicable ......................................................9

(A) Were you able to find a job at the same grade?
   - Yes ..(Go to Q45) ...................................................1
   - No ..(Ask B) .........................................................2
   - Not applicable ......................................................9

(B) What grade did you change to?
   - SHO .................................................................1
   - Registrar ...........................................................2
   - Senior Registrar .................................................3
   - Consultant ..........................................................4
   - Associate Specialist ..........................................5
   - Staff Grade .......................................................6
   - Clinical Assistant ..............................................7
   - Not applicable ....................................................9
5. How much effect do you think that your period of part time training had on your subsequent career progress?

- Large effect on career progress - positive ...................................... (Ask A) .......................... 1
- Large effect on career progress - negative ..................................... (Ask A) .......................... 2
- Some effect on career progress -positive ........................................ (Ask A) .......................... 3
- Some effect on career progress - negative ...................................... (Ask A) .......................... 4
- Neither good or bad effect on career progress ............................ (Go to OA8) .......................... 5
- Don't know ........................................................................... (Go to OA8) .......................... 8
- Not applicable ........................................................................ (Go to OA8) .......................... 9

(a) In what way?

K DOCTORS WHO DID NOT TRAIN PART TIME

- Were there any times when you would have liked to train part time?
  - Yes - would have liked to train part time ........................................... (Go to OA7) .......................... 1
  - No - would not have liked to train part time .................................... (Go to OA8) .......................... 2
  - Don't know ........................................................................... (Go to OA8) .......................... 8
  - Not applicable ........................................................................ (Go to OA8) .......................... 9

K IF YES- WOULD HAVE LIKED TO TRAIN PART TIME:

- (a) When was this?
  - Preo.......................................................................................... 1
  - SHO............................................................................................... 2
  - Registrar ...................................................................................... 3
  - Senior Registrar ........................................................................... 4
  - Consultant .................................................................................... 5
  - Not applicable ........................................................................... 9

- (b) What were your reasons? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>When first child was born.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>When second/third child was born</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>To care for ill relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>To care for elderly relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Personal illness</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason


(c) Why didn’t you work part time?

Code three main reasons mentioned in order stated, Code 9 in remaining box(es) if only 1 or 2 reasons mentioned

Financial considerations .................................................................1
No p/t opportunities in speciality ......................................................2
No knowledge of p/t training schemes ..................................................3
P/T training schemes difficult to access ...............................................4
Presumed detrimental effect on career ..................................................5
Prolonged period of training ...............................................................6
Other reason(SPECIFY) ....................................................................7
Not applicable ......................................................................................9

State other reason


(d) Did being unable to train part time have any effect on your life outside medicine?

Did you take a career break during your medical training? (Career break refers to a period of time not working other than statutory maternity leave; does not apply to unemployment)

Yes (GO to OA4) ................................................................................1
No (GO to OA12) ...............................................................................2

Doctors who have taken a career break:

Did you have any particular reason for taking a career break? (Circle Yes or No for each category)

Yes No
Caring for children. ..........................................................1  2
Caring for elderly relatives .........................................................1  2
Caring for sick relatives ..............................................................1  2
Personal illness .............................................................................1  2
Travel abroad ................................................................................1  2
Other reason(SPECIFY) .................................................................1  2

State other reason


A10. When you returned to work full time in medicine, were you able to find a job in the same specialty?
   Yes ................................................................. 1
   No ................................................................. 2
   No, wanted to change specialties  (Ask A) ................. 3
   Not applicable ................................................. 9

(A) Were you able to find a job at the same grade?
   Yes ................................................................. 1
   No ................................................................. 2
   Not applicable ................................................. 9

(B) What grade did you change to?
   SHO ................................................................. 1
   Registrar ......................................................... 2
   Senior Registrar .............................................. 3
   Consultant ..................................................... 4
   Associate Specialist ......................................... 5
   Staff Grade ..................................................... 6
   Clinical Assistant ........................................... 7
   Not applicable ................................................. 9

A11. How much effect did you think that your career break had on your subsequent career progress? In what way?
   Large effect on career progress - positive  (Ask A) ........... 1
   Large effect on career progress - negative  (Ask A) ........... 2
   Some effect on career progress - positive  (Ask A) ............ 3
   Some effect on career progress - negative  (Ask A) ............ 4
   Neither good or bad effect on career progress  (Ask OA14) . . 5
   Don't know ..................................................... 8
   Not applicable ................................................... 9

(a) In what way?

SK DOCTORS WHO HAVE NOT TAKEN A CAREER BREAK:

12. Were there any times when you were a junior doctor when you would have liked to take a career break?
   Yes - would have liked a career break  (Go to OA13) ........... 1
   No - would not have liked a career break  (Go to OA14) ...... 2
   Don’t know ..................................................... 8
   Not applicable ................................................... 9

SK IF YES - WOULD HAVE LIKED TO TAKE A CAREER BREAK:

13. (a) When was this?
   After medical school ............................................. 1
   FY2O ............................................................... 2
   SHO ............................................................... 3
   Registrar ........................................................ 4
   Senior Registrar .............................................. 5
   Consultant ..................................................... 6
   Not applicable ................................................... 9
(b) What were your reasons?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>When first child was born</td>
<td>1</td>
</tr>
<tr>
<td>When second/third child was born</td>
<td>2</td>
</tr>
<tr>
<td>To care for elderly relatives</td>
<td>3</td>
</tr>
<tr>
<td>To care for sick relatives</td>
<td>4</td>
</tr>
<tr>
<td>Travel abroad</td>
<td>5</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
</tr>
</tbody>
</table>

State other reason

---

(c) Why didn’t you take a career break?

Code three main reasons mentioned in order stated. Code 9 in remaining box(es) if only 1 or 2 reasons mentioned.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial considerations</td>
<td>1</td>
</tr>
<tr>
<td>Opportunities not available in speciality at time</td>
<td>2</td>
</tr>
<tr>
<td>Presumed detrimental effect on career</td>
<td>3</td>
</tr>
<tr>
<td>Prolonged period of training</td>
<td>4</td>
</tr>
<tr>
<td>Other reason (SPECIFY)</td>
<td>5</td>
</tr>
</tbody>
</table>

State other reason

---

ASK FOR ALL - APART FROM TRAVEL ABROAD

(d) Did being unable to take a career break have any effect on your life outside medicine?
A14. Did you work abroad at any time when you were a junior doctor (or since arriving in this country)?

This does not apply to time working abroad when they were a medical student:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(GO TO QA15)</td>
</tr>
<tr>
<td>No</td>
<td>(GO TO QA18)</td>
</tr>
</tbody>
</table>

**ASK DOCTORS WHO HAVE WORKED ABROAD:**

15. Why did you want to work abroad? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain experience of working in another country</td>
<td>1</td>
</tr>
<tr>
<td>Become better qualified in field</td>
<td>2</td>
</tr>
<tr>
<td>Research Fellowship</td>
<td>1</td>
</tr>
<tr>
<td>Other (State)</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason

16. When you returned to work in medicine in Britain were you able to find a job in the same speciality?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(Ask A)</td>
</tr>
<tr>
<td>No</td>
<td>(Ask A)</td>
</tr>
<tr>
<td>No, wanted to change specialities</td>
<td>(Ask A)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
</tr>
</tbody>
</table>

(A) Were you able to find a job at the same grade?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>.........................................................</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>.........................................................</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>.........................................................</td>
<td>9</td>
</tr>
</tbody>
</table>

(B) What grade did you change to?

<table>
<thead>
<tr>
<th>grade</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Registrar</td>
<td>2</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>3</td>
</tr>
<tr>
<td>Consultant</td>
<td>4</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>5</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Assistant</td>
<td>7</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
</tr>
</tbody>
</table>
A17. How much effect did working abroad have on your subsequent career progress?

Large effect on career progress - positive ..................(Ask A) ........1
Large effect on career progress - negative ..................(Ask A) ........2
Some effect on career progress - positive ..................(Ask A) ........3
Some effect on career progress - negative ..................(Ask A) ........4
Neither good or bad effect on career ..............................(GO to QA18) ...5
Don’t know ......................................................................(Go to QA18) ...8
Not applicable .................................................................9

(a) In what way?
A18. During your medical training did you have any periods of employment working in jobs other than medicine?

- Yes  (Go to OA19) .......................................................... 1
- No  (Go to OA23) .......................................................... 2

ASK DOCTORS WHO HAVE WORKED IN JOBS OTHER THAN MEDICINE DURING THEIR MEDICAL TRAINING:

A19. What area of work did you change to? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Journalist</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Armed Forces</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Civil Service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medical Research Council</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other area (State other area)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other area

A20. Why did you decide to work in this area? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disillusioned with medicine</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Gain wider experience of medicine</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Opportunity available at time</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other reason (State)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason

A21. When you obtained a job in medicine again, was it in the same speciality?

- Yes  (Ask A) .......................................................... 1
- No  (Ask A) .......................................................... 2
- No, wanted to change specialities  (Ask A) .......................................................... 3
- Not applicable .......................................................... 9

(A) Were you able to find a job at the same grade?

- Yes  (Ask OA22) .......................................................... 1
- No  (Ask B) .......................................................... 2
- Not applicable .......................................................... 9

(B) What grade did you change to?

- Senior Registrar ...................................................... 3
- Consultant ............................................................. 4
- Associate Specialist ................................................ 5
- Staff Grade ............................................................ 6
- Clinical Assistant ................................................... 7
- Not applicable ........................................................ 9
A22. How much effect did you think this had on your subsequent career progress? In what way?

<table>
<thead>
<tr>
<th>Effect on Career Progress</th>
<th>Positive</th>
<th>(Ask A)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large effect on career progress</td>
<td>negative</td>
<td>(Ask A)</td>
<td>2</td>
</tr>
<tr>
<td>Some effect on career progress</td>
<td>positive</td>
<td>(Ask A)</td>
<td>3</td>
</tr>
<tr>
<td>Some effect on career progress</td>
<td>negative</td>
<td>(Ask A)</td>
<td>4</td>
</tr>
<tr>
<td>Neither good or bad effect on career</td>
<td></td>
<td>(Go to OA23)</td>
<td>5</td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td>(Go to OA23)</td>
<td>8</td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td>(Go to OA23)</td>
<td>9</td>
</tr>
</tbody>
</table>

(a) In what way?

UK ALL DOCTORS

L23. Why did you choose your current speciality?

Code four main reasons mentioned in order stated. Code 9 in remaining box(es) if only 1 or 2 reasons mentioned.

<table>
<thead>
<tr>
<th>Reason</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal interest in type of work</td>
<td>Ask A</td>
<td>1</td>
</tr>
<tr>
<td>Working hours</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Good training programme</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Working environment</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Opportunity available</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Length of training</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Good opportunities to become a consultant</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Less competition in specialty</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Other (State)</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

State other reason

IF REASON WAS PERSONAL INTEREST

(a) What in particular did you enjoy about the speciality? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Enjoyment</th>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical interest in work</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Work with people (social care, mind and body)</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Emergency work</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Job satisfaction in seeing patients get better relatively quickly</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Variety of type of patient</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Stimulating work</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
ASK IF CHOICE WAS NOT SURGERY OR OBSTETRICS & GYNAECOLOGY:

A24. Did you at any time consider a career in surgery or obstetrics and gynaecology?
   Yes - surgery .................................................................1
   Yes, obs & gynae.........................................................2
   Yes, both.................................................................3
   None of the above..........................................................4
   Not applicable..................................................................9

ASK IF YES:
   (a) What made you change your mind?

would like to now ask you some questions about your domestic situation

25. Are you currently married, cohabiting, divorced, separated, widowed or single?
   Single (GO TO SECTION B)................................................1
   Married (GO TO SECTION C)............................................2
   Cohabiting(GO TO SECTION C)...........................................3
   Divorced/Separated/(GO TO SECTION E)..............................4
   Widowed (GO TO SECTION F)...........................................5
SECTION B ASK IF SINGLE

1. On average, when do you leave home in the morning and return in the evening during a normal working day?
   - Before 8 a.m ..................................................1
   - Between 8 and 9 a.m ........................................2
   - After 9 a.m ..................................................3
   - Before 5 p.m ................................................1
   - Between 5 p.m and 6 p.m ..................................2
   - After 6 p.m and before 7 p.m ..............................3
   - After 7 p.m ..................................................4

   (a) Do you work at weekends? Is this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)
   - On call at hospital/surgery ............................... (Ask b) 1
   - On call at home .............................................. (Ask b) 1
   - Working at home ............................................ (Ask b) 1
   - Other employment outside the home ........................ (Ask b) 1

   (b) How often is this?
   - Every weekend..............................................1
   - 1 in 2 ................................................................2
   - 1 in 3 ................................................................3
   - 1 in 4 ................................................................4
   - Less than 1 in 4 ................................................5

   (c) On average, how many hours do you work a week in the hospital?
   (d) On average, how many extra hours do you work a week outside the hospital?

2. Do you have any children? How many?
   - Yes: One ......................................................... (Ask A) 1
   - Two ................................................................. (Ask A) 2
   - Three .............................................................. (Ask A) 3
   - Four ................................................................. (Ask A) 4
   - Five or more .............................. (Ask A) 5
   - No (GO TO SECTION F) ........................................6

   (a) How old are they? (Circle Yes or No if children in age group)
   - Under two years...............................................1
   - 2-5 years..........................................................1
   - 6-10 years .......................................................1
   - 11-16 years .....................................................1
   - Over 16 years ..................................................1

   (b) Do your children live with you?
   - Yes .....................................................................1
   - No .....................................................................2
   - Not applicable ......................................................9
B3. Does anyone else live in your household?
Yes .................................................................1
No .................................................................2

(a) Who is this?
Nanny ...............................................................1
Parents/Grandparents .............................................2
Other relatives ....................................................3
Other people ......................................................4
Not applicable.....................................................9

If Children Under Five Years: - GO TO OB4
If Children Under Five Years Plus Children Over Five: - GO TO OB4
If Children aged between Five and sixteen Years GO TO OB9
If Children over 16 years go to OB14

SK DOCTORS WITH CHILDREN UNDER FIVE YEARS OLD/ CHILDREN UNDER FIVE YEARS OLD PLUS CHILDREN OVER FIVE YEARS

4. Who looks after your children when you are at work?  (Circle Yes or No for each category)

Yes No
Live in Nanny ...................................................1 2
Nanny(not live in) ................................................1 2
Childminder .....................................................1 2
Nursery/ Nursery School ......................................1 2
Day time care by relatives ....................................1 2
Other.(State) ...................................................1 2

State other reason
B5. Do you have any practical childcare support from (other) family, friends or neighbours? Who?
(Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Support Ask (a & b)
If No Support Ask (b)

(a) What support do they give? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available during an emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking to/from School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

State other reason

(b) In total, how many hours a week of childcare support is provided by other people?

Not applicable...99

16. Do you currently employ (other) outside domestic help? e.g cleaner, gardener.

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes (a) How often do they come to the house?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a fortnight - full day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once a fortnight - half day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One half day a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two half days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 half days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 or more half days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If No: (b) Have you employed any outside domestic help in the past?

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you ask if employ paid help

' How important is it for you to employ outside domestic help?

<table>
<thead>
<tr>
<th>Importance</th>
<th>Very important</th>
<th>Important</th>
<th>Not very important</th>
<th>Don't Know</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B8. Do you go away from home for conferences at any time?

Yes, ..................................................(Ask a).................................1
No, not able to because of domestic commitments......................................2
No, does not wish to attend conferences ..................................................3

(a) How are childcare arrangements organised?

GO TO QUESTION B18
### B9. Who looks after your children after school when you are at work? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent at home when children return from school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Live in Nanny</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nanny(not live in)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursery/ Nursery School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Day time care by relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children at boarding school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (State)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**State other person**


### 10. Do you have any practical childcare support from (other) family, friends or neighbours? Who? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neighbours</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**If Yes-support ask (a & b)**

**If No-Support ask (b)**

**If Yes-support ask (a & b)**

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**State other reason**


**If No-support ask (b)**

**In total, how many hours a week of childcare support is provided by other people?**

Not applicable........99
BI1. Do you currently employ (other) outside domestic help? e.g. cleaner, gardener.
   Yes (ASK A) ................................................................. 1
   No (ASK B) ................................................................. 2

   If Yes (a) How often do they come to the house?
      Once a fortnight - full day ........................................... 1
      Once a fortnight - half day ......................................... 2
      One half day a week ................................................. 3
      Two half days a week ............................................... 4
      3 half days a week ................................................... 5
      4 or more half days a week ....................................... 6
      Not applicable ....................................................... 9

   If No; (b) Have you employed any outside domestic help in the past?
      Yes ................................................................. 1
      No ................................................................. 2
      Not applicable ....................................................... 9

*Only ask if employ paid help*

312 How important is it for you to employ outside domestic help?
   Very important.......................................................... 1
   Important .............................................................. 2
   Not very important .................................................. 3
   Don’t Know ............................................................ 8
   Not applicable ........................................................ 9

313 Do you go away from home for conferences at any time?
   Yes, ................................................................. (Ask a) 1
   No, not able to because of domestic commitments (Go to OB14) 2
   No, does not wish to attend conferences (Go to OB14) 3

   (a) How are childcare arrangements organised?
I would like to ask you some questions about when your children were under five years old.

Refer to Work History Sheet - if information not already known ASK:

B14. Did you work full time when your children were under five years old?

- Worked full time ...........................................1
- Worked part time ...........................................2
- Respondent did not work ..................................3

B15. On average, when did you leave home in the morning and return in the evening during a normal working day when your children were under five years old?

- Before 8 a.m ..................................................1
- Between 8 and 9 a.m .........................................2
- After 9 a.m ...................................................3
- Before 5 p.m ...................................................1
- Between 5 p.m and 6 p.m ...................................2
- After 6 p.m and before 7 p.m ..............................3
- After 7 p.m ...................................................4

(a) Did you work at weekends? Was this on call at hospital/on call at home/working at home?  
On call at hospital/surgery .......................(Ask b)...............1  2
On call at home ..................................(Ask b)...............1  2
Working at home .........................................(Ask b)...............1  2
Other employment outside the home ..............(Ask b)...............1  2

(b) How often was this?
Every weekend ...........................................1
1 in 2 ......................................................2
1 in 3 ......................................................3
1 in 4 ......................................................4
Less than 1 in 4 ..........................................5

(c) On average, how many hours did you work a week in the hospital when your children were under five years old?  Not applicable......99

(d) On average, how many extra hours did you work a week outside the hospital when your children were under five years old?  Not applicable......99

Only ask those doctors who worked when children were young

16. When your children were under five years old, who looked after them when you were at work? (Circle Yes or No for each category)

- Live in Nanny ..............................................1  2
- Nanny(not live in) .........................................1  2
- Childminder .................................................1  2
- Nursery/ Nursery School ...............................1  2
- Day time care by relatives ............................1  2
- Children at boarding school ............................1  2
- Other ..........................................................1  2

State other reason

__________________________________________________________________
B17. Did you have any practical childcare support from (other) family, friends or neighbours? Who?
(Circle Yes or No for each category)

Yes No

Friends ..........................................................1 2
Relatives ..........................................................1 2
Neighbours ..........................................................1 2

If Yes-support Ask (a & b)
If No-support Ask (b)

(a) What support did they give? (Circle Yes or No for each category)

Yes No

Babysitting .........................................................1 2
Children stay with them during exam time ................................1 2
Children stay with them during holidays/half term .....................1 2
Available during an emergency .........................................1 2
Taking to/from School ................................................1 2
Other (SPECIFY) .......................................................1 2

State other support

(b) In total, how many hours of childcare support a week was provided by other people when your children were under five years old?

Not applicable............99

8 In your opinion, has having a family had any effect on your career progression?

Yes - good effect...(Ask A) ........................................1
Yes - bad effect ...(Ask A) ..........................................2
No effect........(Go to OB19) ........................................3

If Yes: (a) In what way?
B19. Do you think your career progression has had any effect on your family life?
   Yes - good effect..(Ask A & B). ................................................................. 1
   Yes - bad effect ..(Ask A & B). ................................................................. 2
   No effect ..................(Go to Section F) .................................................. 3

If Yes: (a) In what way?

(b) How do you feel about this?

**GO TO SECTION F**
SECTION C  IF MARRIED OR COHABITING

1. Could you tell me at what grade in your career you got married/began living with your current partner?
   At medical school .................................................................1
   PHO .........................................................................................2
   SEO .........................................................................................3
   Registrar ..................................................................................4
   Senior Registrar ........................................................................5
   Consultant ..................................................................................6
   Associate Specialist ....................................................................7
   Staff Grade ................................................................................10
   Clinical Assistant .......................................................................11

2. Have you been married or cohabited before? (Only include periods of cohabitation for 12 months or more)
   Yes (Go to Section D) .................................................................1
   No ..............................................................................................2

3. Is your husband/wife/partner currently employed?
   Employed part time .................................................................1
   Employed - full time .................................................................2
   Self employed ............................................................................3
   Unemployed ...............................................................(ASK B) .........4
   Housewife .................................................................................5
   Retired ......................................................................................6

   (a) What is your husband/wife/partner's occupation?
       (State occupation.................................................................)

   (b) What was your husband/wife/partner's last occupation?
       (State occupation.................................................................)

ASK IF HUSBAND/WIFE/PARTNER WORKING

On average, when does your husband/wife/partner leave home in the morning and return in the evening during a normal working day?

   Before 8 a.m ...............................................................................1
   Between 8 and 9 a.m ...................................................................2
   After 9 a.m ..................................................................................3

   Before 5 p.m ...............................................................................1
   Between 5 p.m and 6 p.m ..............................................................2
   After 6 p.m and before 7 p.m .......................................................3
   After 7 p.m ..................................................................................4
(a) Does he/she work at weekends? Is this on call at hospital/on call at home/working at home? Circle Yes or No for each category

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often is this?

- Every weekend                                 1
- 1 in 2                                        2
- 1 in 3                                        3
- 1 in 4                                        4
- Less than 1 in 4                              5

(c) On average, how many hours a week does your husband/wife/partner work at his/her place of work? Not applicable...99

(d) On average, how many extra hours a week does your husband/wife/partner work outside his place of work? Not applicable...99

5. On average, when do you leave home in the morning and return in the evening during a normal working day?

- Before 8 a.m                                   1
- Between 8 and 9 a.m                            2
- After 9 a.m                                    3
- Before 5 p.m                                   1
- Between 5 p.m and 6 p.m                        2
- After 6 p.m and before 7 p.m                  3
- After 7 p.m                                    4

(a) Do you work at weekends? Is this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often is this?

- Every weekend                                 1
- 1 in 2                                        2
- 1 in 3                                        3
- 1 in 4                                        4
- Less than 1 in 4                              5

(c) On average, how many hours a week do you work in the hospital? Not applicable...99

(d) On average, how many hours a week do you work outside the hospital? Not applicable...99
C6. I asked for your work history because we are trying to gather a career and life history for each doctor. It would be helpful if I could gather information on your husband/wife/partner's career history from the time you met. Would you mind helping me fill in these details [SHOW SHEET]

C7. To what extent does your husband/wife/partner support you in your career progression?
   A great deal of support (Ask a).................................................................1
   Some support........... (Ask a)........................................................................2
   Very little support........ (Ask c)........................................................................3
   Not at all .................(Ask c)...........................................................................4

   (a) Has he/she always given you this support?
      Yes ................................(Ask d & e).................................................................1
      No .........................(Ask b, c, d, e)...............................................................2

   (b) Could you please explain?

   (c) How do you feel about this?
(d) In what ways does he/she support you? (Code Yes or No according to category)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional/moral support</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practical support</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other ways (Specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other ways:

(e) Does he/she support you when you have to work long hours?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>Rarely</td>
<td>3</td>
</tr>
</tbody>
</table>

8. Do you have any children? How many?

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>1</td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
</tr>
<tr>
<td>Four</td>
<td>4</td>
</tr>
<tr>
<td>Five or more</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
</tr>
</tbody>
</table>

(a) How old are they? (Circle Yes or No if doctor has children in category)

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under two years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2-5 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11-16 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Over 16 years</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Children Under Five Years: - GO TO OC9
If Children Under Five Years Plus Children Over Five: - GO TO OC9
If Children aged between Five and Sixteen Years GO TO OC17
If all children over sixteen years go to OC24

If No children:

(b) Was your career a contributory factor towards this?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
</tr>
</tbody>
</table>

(c) In what way?
ASK DOCTORS WITH CHILDREN UNDER FIVE YEARS OLD/CHILDREN UNDER FIVE YEARS OLD PLUS OTHER CHILDREN OVER FIVE YEARS OLD

C9. Who looks after your children when you are at work? (Pre school children and after school care for older children) (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live in Nanny</td>
<td>1</td>
</tr>
<tr>
<td>Nanny (not live in)</td>
<td>2</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
</tr>
<tr>
<td>Nursery</td>
<td>1</td>
</tr>
<tr>
<td>Day care by relatives</td>
<td>2</td>
</tr>
<tr>
<td>Partner</td>
<td>2</td>
</tr>
<tr>
<td>Children at boarding school</td>
<td>1</td>
</tr>
</tbody>
</table>

C10. Do you have any practical childcare support from (other) family, friends or neighbours? Who? (Circle Yes or No for each category)

If Yes—Support Ask (a & b)
If No Support Ask (b)

(a) What support do they give? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
</tr>
<tr>
<td>Children stay with then during exam time</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>2</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
</tr>
<tr>
<td>State other reason</td>
<td></td>
</tr>
</tbody>
</table>

(b) In total, how many hours a week of childcare support is provided by other people?

Not applicable

Not applicable
C11. How do you and your husband/wife/partner share childrearing responsibilities (for your children under five?) (i.e. Who dresses, feeds, takes children to childminder, picks children up from school, who takes them out for leisure etc) I have a list of activities, if we start with............

<table>
<thead>
<tr>
<th>Code according to following</th>
<th>R=Respondent</th>
<th>P=Partner</th>
<th>PC=Paid help by other person</th>
<th>IC=Unpaid help by other person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity..........................1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Majority of time does activity................2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half the time does the activity................3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes does activity........................4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never does activity............................5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable.................................9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Gets children up and dressed and fed in morning | [ ] | [ ] | [ ] | [ ] |
| Takes children to nursery/childminder | [ ] | [ ] | [ ] | [ ] |
| Picks children up from nursery/childminder | [ ] | [ ] | [ ] | [ ] |
| Feeds children in evening | [ ] | [ ] | [ ] | [ ] |
| Bathes children | [ ] | [ ] | [ ] | [ ] |
| Puts children to bed | [ ] | [ ] | [ ] | [ ] |
| Takes children out for leisure activities | [ ] | [ ] | [ ] | [ ] |
| Buys clothes for children | [ ] | [ ] | [ ] | [ ] |
| Gets childrens hair cut | [ ] | [ ] | [ ] | [ ] |
| Takes them to the doctors | [ ] | [ ] | [ ] | [ ] |
| Takes time off work when children/nanny was ill | [ ] | [ ] | [ ] | [ ] |

*LY ASK THOSE DOCTORS WITH CHILDREN THAT ARE BOTH OVER FIVE YEARS AND UNDER FIVE YEARS OLD.*

12. How do you and your husband/wife/partner share childrearing responsibilities for your older children. I have a list of activities, if we start with.................

<table>
<thead>
<tr>
<th>Code according to following</th>
<th>R=Respondent</th>
<th>P=Partner</th>
<th>PC=Paid help by other person</th>
<th>IC=Unpaid help by other person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity..........................1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Majority of time does activity................2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half the time does the activity................3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes does activity........................4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never does activity............................5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable.................................9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Takes children to school | [ ] | [ ] | [ ] | [ ] |
| Picks children up from school | [ ] | [ ] | [ ] | [ ] |
| Buys clothes | [ ] | [ ] | [ ] | [ ] |
| Oversees homework | [ ] | [ ] | [ ] | [ ] |
| Takes children to leisure activities/classes | [ ] | [ ] | [ ] | [ ] |
| Takes time off work if children/nanny ill | [ ] | [ ] | [ ] | [ ] |
| Feeds children in evening | [ ] | [ ] | [ ] | [ ] |
| Goes to school during the day if needed | [ ] | [ ] | [ ] | [ ] |
| Talks with children about their emotional worries | [ ] | [ ] | [ ] | [ ] |
ASK ALL DOCTORS:

C13. Do you currently employ (other) outside domestic help? e.g cleaning lady, gardener

Yes (ASK A) .................................................................1
No (ASK B) .................................................................2

If Yes (a) How often do/they does he/she come to the house?
Once a fortnight - full day ...........................................1
Once a fortnight - half day ..........................................2
One half day a week ....................................................3
Two half days a week ..................................................4
3 half days a week .....................................................5
4 or more half days a week ..........................................6
Not applicable .............................................................9

If No: (b) Have you employed any outside domestic help in the past?
Yes .................................................................1
No .................................................................2
Not applicable .............................................................9
14. Could you tell me how you and your husband/wife/partner share household tasks? (Code the main person that does each task)

Code according to following

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Solely does activity</td>
</tr>
<tr>
<td>2</td>
<td>Majority of time does activity</td>
</tr>
<tr>
<td>3</td>
<td>Half the time does the activity</td>
</tr>
<tr>
<td>4</td>
<td>Sometimes does activity</td>
</tr>
<tr>
<td>5</td>
<td>Never does activity</td>
</tr>
<tr>
<td>6</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Cleaning house
Cooking meals
Washing dishes>Loading dishwasher
Food shopping
Laundry
Ironing
DIY
Gardening
Decorating
Car maintenance

15. How important is it for you to employ practical help with household tasks?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very important</td>
</tr>
<tr>
<td>2</td>
<td>Important</td>
</tr>
<tr>
<td>3</td>
<td>Not very important</td>
</tr>
<tr>
<td>4</td>
<td>Don’t Know</td>
</tr>
</tbody>
</table>

16. Do you or your husband/wife/partner go away from home for conferences at any time?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, partner only.(Ask A)</td>
</tr>
<tr>
<td>2</td>
<td>Yes, Respondent (Ask A)</td>
</tr>
<tr>
<td>3</td>
<td>Yes, both (Ask A)</td>
</tr>
<tr>
<td>4</td>
<td>No, partner not able to because of domestic commitments (GO TO C30)</td>
</tr>
<tr>
<td>5</td>
<td>No, respondent not able to because of domestic commitments (GO TO C30)</td>
</tr>
<tr>
<td>6</td>
<td>No, partner does not wish to attend conferences (GO TO C30)</td>
</tr>
<tr>
<td>7</td>
<td>No, respondent does not wish to attend conferences (GO TO C30)</td>
</tr>
</tbody>
</table>

(a) If Yes: How are childcare arrangements organised?

GO TO QUESTION C30
**ONLY ASK DOCTORS WITH CHILDREN AGED BETWEEN FIVE AND SIXTEEN YEARS:**

### Q17. Who looks after your children after school when you are at work? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent at home when children return from school</td>
<td>1</td>
</tr>
<tr>
<td>Live in Nanny</td>
<td>1</td>
</tr>
<tr>
<td>Nanny (not live in)</td>
<td>1</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
</tr>
<tr>
<td>Nursery</td>
<td>1</td>
</tr>
<tr>
<td>Day care by relatives</td>
<td>1</td>
</tr>
<tr>
<td>Partner</td>
<td>1</td>
</tr>
<tr>
<td>Children at boarding school</td>
<td>1</td>
</tr>
</tbody>
</table>

### Q18. Do you have any practical childcare support from (other) family, friends or neighbours? Who? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>1</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
</tr>
<tr>
<td>Neighbours</td>
<td>1</td>
</tr>
</tbody>
</table>

**If Yes—Support Ask (a & b)
If No Support Ask (b)**

(a) What support do they give? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td>1</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>1</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
</tr>
</tbody>
</table>

State other reason

(b In total, how many hours a week of childcare support is provided by other people?
Not applicable................. 99
C19. How do you and your husband/wife/partner currently share childrearing responsibilities?

<table>
<thead>
<tr>
<th>Code according to following</th>
<th>P (Respondent)</th>
<th>P (Partner)</th>
<th>PC (Paid help by other person)</th>
<th>IC (Unpaid help by other person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Majority of time does activity...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half the time does the activity...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes does activity........</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never does activity............</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable..................</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Takes children to school
Picks children up from school
Buys clothes
Oversees homework
Takes children to leisure activities/classes
Takes time off work if children/nanny ill
Feeds children in evening
Goes to school during the day if needed
Talks with children about their emotional worries

C20. Do you currently employ outside domestic help? e.g cleaning lady, gardener

<table>
<thead>
<tr>
<th>Yes (ASK A)</th>
<th>No (ASK B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------------</td>
<td>------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes (a) How often do they does he/she come to the house?

<table>
<thead>
<tr>
<th>Once a fortnight - full day</th>
<th>Once a fortnight - half day</th>
<th>One half day a week</th>
<th>Two half days a week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If No: (b) Have you employed any outside domestic help in the past?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----</td>
<td>----</td>
<td>----------------</td>
</tr>
<tr>
<td>-----</td>
<td>----</td>
<td>----------------</td>
</tr>
<tr>
<td>-----</td>
<td>----</td>
<td>----------------</td>
</tr>
<tr>
<td>-----</td>
<td>----</td>
<td>----------------</td>
</tr>
</tbody>
</table>
C21. Could you tell me how you and your husband/wife/partner share household tasks? (Code the main person that does each task)

**Code according to following**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity</td>
<td>1</td>
</tr>
<tr>
<td>Majority of time does activity</td>
<td>2</td>
</tr>
<tr>
<td>Half the time does the activity</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes does activity</td>
<td>4</td>
</tr>
<tr>
<td>Never does activity</td>
<td>5</td>
</tr>
<tr>
<td>Not applicable</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing dishes/Loading dishwasher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ironing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decorating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Only ask if doctor has paid help*

C22. How important is it for you to employ practical help with household tasks?

- Very important: .......................... 1
- Important: .................................. 2
- Not very important: .......................... 3
- Don't Know: .................................. 8

C23. Do you or your husband/wife/partner go away from home for conferences at any time?

- Yes, partner: .............................. 1
- Yes, Respondent: ........................... 2
- Yes, both: ................................ 3
- No, partner not able to because of domestic commitments (Go to C24) 4
- No, respondent not able to because of domestic commitments (Go to C24) 5
- No, partner does not wish to attend conferences: ........................... 6
- No, respondent does not wish to attend conferences: ........................... 7

(a) If Yes: How are childcare arrangements organised?
I would like to ask you some questions about when your children were under five years old.

Refer to Work History Sheet, if information not already collected ask:

C24. Did you and your husband/wife/partner both work full time when your children were under five years old?

- Both worked full time ..............................................1
- Respondent worked full time, partner worked part time...........2
- Respondent worked part time, partner worked full time ..........3
- Respondent worked full time, partner didn’t work.................4
- Respondent didn’t work, partner worked full time...............5

ASK IF RESPONDENT WORKED WHEN CHILDREN WERE YOUNG

C25. On average, when did you leave home in the morning and return in the evening during a normal working day when your children were under five years old?

- Before 8 a.m ..........................................................1
- Between 8 and 9 a.m ..............................................2
- After 9 a.m ............................................................3
- Before 5 p.m ..........................................................1
- Between 5 p.m and 6 p.m .........................................2
- After 6 p.m and before 7 p.m ....................................3
- After 7 p.m ............................................................4

(a) Did you work at weekends? Was this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often was this?

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Every weekend</td>
<td>1</td>
</tr>
<tr>
<td>1 in 2</td>
<td>2</td>
</tr>
<tr>
<td>1 in 3</td>
<td>3</td>
</tr>
<tr>
<td>1 in 4</td>
<td>4</td>
</tr>
<tr>
<td>Less than 1 in 4</td>
<td>5</td>
</tr>
</tbody>
</table>

(c) On average, how many hours a week did you work a week in the hospital when your children were under five years old? Not applicable...99

(d) On average, how many extra hours a week did you work outside the hospital when your children were under five years old? Not applicable...99
ASK IF PARTNER WORKED WHEN CHILDREN WERE YOUNG

C26. On average, when did your husband/wife/partner leave home in the morning and return in the evening during a normal working day when your children were under five years old?

<table>
<thead>
<tr>
<th>Time</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 8 a.m.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Between 8 and 9 a.m</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>After 9 a.m</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Before 5 p.m.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Between 5 p.m and 6 p.m</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>After 6 p.m and between 7 p.m</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>After 7 p.m.</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

(a) Did he/she work at weekends? Was this on call at hospital/on call at home/working at home?
(Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often was this?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every weekend</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1 in 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1 in 3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1 in 4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Less than 1 in 4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

(c) On average, how many hours a week did your husband/wife/partner work in his/her place of work when your children were under five years old?

Not applicable...99

(d) On average, how many extra hours a week did your husband/wife/partner work outside his/her place of work when your children were under five years old?

Not applicable...99

Only ask if respondent worked when children were young

C27. When your children were under five years old who looked after them when you were at work? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Care Provider</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live in Nanny</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nanny (not live in)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursery/Nursery School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Day time care by relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Partner</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (State)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other person
C28. Did you have any practical childcare support from family, friends or neighbours? Who? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neighbours</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes—support Ask (a & b)
If No—support Ask (b)

(a) What support did they give? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason

(b) In total, how many hours a week of childcare support was provided by other people when your children were under five years old?

Not applicable...99

C29. When your children were under five years old how did you and your husband/wife/partner share childrearing responsibilities? (i.e. Who dresses, feeds, takes children to childminder; who takes them out for leisure etc)

Code according to following

<table>
<thead>
<tr>
<th>Activity</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Majority of time does activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half the time does the activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes does activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never does activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Got children up and dressed in morning
Took children to nursery/childminder
Picked children up from nursery/childminder
Fed children in evening
Bathed children
Put children to bed
Took children out for leisure activities
Bought clothes for children
Took then to the doctors
Took time off work when children/nanny was ill
C30. In your opinion, has having a family had any effect on your career progression?
   Yes - good effect ...(ask a).................................................................1
   Yes - bad effect ...(ask a).................................................................2
   No effect ...{(Go to QC31)}...............................................................3

   If Yes: (a) In what way?

C31. Do you think your career progression has had any effect on your family life?
   Yes - good effect ...(ask a & b)............................................................1
   Yes - bad effect ...(ask a & b)............................................................2
   No effect ......{(Go to Section F)}.........................................................3

   If Yes: (a) In what way?
(b) How do you feel about this?

**GO TO SECTION F**
SECTION D  ASK FOR DOCTORS PREVIOUSLY MARRIED/ OR PREVIOUSLY COHABITED

I would like to ask some questions about your previous marriage/partner

D1. Do you mind telling me when you were divorced/separated from your first husband/wife/partner? (State grade)

   At medical school ................................................................. 1
   PRHO ................................................................. 2
   SHO ................................................................. 3
   Registrar ................................................................. 4
   Senior Registrar ................................................................. 5
   Consultant ................................................................. 6
   Associate Specialist ................................................................. 7
   Staff Grade ................................................................. 10
   Clinical Assistant ................................................................. 11

D2. Do you think your career in medicine had any effect on your divorce/separation?

   A large effect ................................................................. 1
   Some effect ................................................................. 2
   No effect ................................................................. 3

   (a) Do you mind telling me in what way?
D3. Was your husband/wife/partner employed for the majority of the time you were married/living together?  
(Code state of employment for the majority of the marriage)

- Employed part time (ASK A) .......................................................... 1
- Employed - full time (ASK A) .......................................................... 2
- Self employed  (ASK A) ................................................................. 3
- Unemployed  (ASK B) ........................................................................... 4
- Housewife (ASK B) ............................................................................... 5
- Retired  (ASK B) ................................................................................... 6

(a) What was his/her occupation?

(State occupation..........................................................)

(b) What was his/her last occupation?

(State occupation..........................................................)

D4. I asked for your work history because we are trying to gather a career and life history for each doctor. It would be helpful if I could gather information on your first husband/wife’s career history from the time you met until you separated. Would you mind helping me fill in these details [SHOW SHEET]

D5. To what extent did your husband/wife/partner support you in your career progression?

- A great deal of support (Ask a) ........................................................... 1
- Some support (Ask a) ......................................................................... 2
- Very little support (Ask c) ................................................................. 3
- Not at all (Ask c) ................................................................................... 4

(a) Did he/she always give you this support?

- Yes (Ask d & e) ..................................................................................... 1
- No (Ask b, c, d, e) .................................................................................. 2

(b) Could you please explain?

(c) How do you feel about this?
(d) In what ways did he/she support you? *(Code Yes or No according to category)*

<table>
<thead>
<tr>
<th>支持方式</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>情感/道德支持</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>实际支持</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>其他方式（具体）</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**State other ways:**

（e）他/她是否在你工作长时间时提供支持？

<table>
<thead>
<tr>
<th>状态</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>全部时间</td>
<td>1</td>
</tr>
<tr>
<td>大部分时间</td>
<td>2</td>
</tr>
<tr>
<td>很少时间</td>
<td>3</td>
</tr>
</tbody>
</table>
D6. Did you have any children with your previous partner?

Yes: One ..............................................1
      Two ..............................................2
      Three ..........................................3
      Four .............................................4
      Five or more ..................................5

No ...............................................6

(a) How old are they?  (Circle Yes or No if children in each category)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under two years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2-5 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11-16 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Over 16 years</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If No children:
(b) Was your career a contributory factor towards this?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>(Go to QD16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) In what way?

I would like to ask you some questions about how you and your first husband/wife/previous partner shared childcare arrangements when you were married/living together.

Refer to Work History Sheet, if information not already collected ask:

D7. Did you and your husband/wife/partner both work full time when your children were under five years old?

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both</td>
<td>Worked full time</td>
<td>1</td>
</tr>
<tr>
<td>Respondent</td>
<td>Worked full time, partner worked part time</td>
<td>2</td>
</tr>
<tr>
<td>Respondent</td>
<td>Worked part time, partner worked full time</td>
<td>3</td>
</tr>
<tr>
<td>Respondent</td>
<td>Worked full time, partner didn’t work</td>
<td>4</td>
</tr>
<tr>
<td>Respondent</td>
<td>Didn’t work, partner worked full time</td>
<td>5</td>
</tr>
</tbody>
</table>
D8. On average, when did you leave home in the morning and return in the evening during a normal working day when your children were under five years old?

Before 8 a.m .................................................................1
Between 8 and 9 a.m .....................................................2
After 9 a.m. ......................................................................3

Before 5 p.m. .................................................................1
Between 5 p.m and 6 p.m ..................................................2
After 6 p.m and before 7 p.m ............................................3
After 7 p.m. ......................................................................4

(a) Did you work at weekends? Was this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often was this?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every weekend</td>
<td>1</td>
</tr>
<tr>
<td>1 in 2</td>
<td>2</td>
</tr>
<tr>
<td>1 in 3</td>
<td>3</td>
</tr>
<tr>
<td>1 in 4</td>
<td>4</td>
</tr>
<tr>
<td>Less than 1 in 4</td>
<td>5</td>
</tr>
</tbody>
</table>

(c) On average, how many hours a week did you work in the hospital when your children were under five years old? Not applicable...99

(d) On average, how many extra hours a week did you work outside the hospital when your children were under five years old? Not applicable...99

D9. On average, when did your husband/wife/partner leave home in the morning and return in the evening during a normal working day when your children were under five years old?

Before 8 a.m ....................................................................1
Between 8 and 9 a.m .....................................................2
After 9 a.m. ......................................................................3

Before 5 p.m. .................................................................1
Between 5 p.m and 6 p.m ..................................................2
After 6 p.m and before 7 p.m ............................................3
After 7 p.m. ......................................................................4

(a) Did he/she work at weekends? Was this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
(b) How often was this?

- Every weekend: 1
- 1 in 2: 2
- 1 in 3: 3
- 1 in 4: 4
- Less than 1 in 4: 5

(c) On average, how many hours a week did your husband/wife/partner work at their place of work when your children were under five years old? Not applicable...99

(d) On average, how many extra hours a week did your husband/wife/partner work outside their place of work when your children were under five years old? Not applicable...99

**ONLY ASK DOCTORS WHO WORKED WHEN THEIR CHILDREN WERE YOUNG**

D10. When your children were under five years old who looked after them when you were at work? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>*</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live in Nanny</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nanny (not live in)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursery/Nursery School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Day time care by relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Partner</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other person

D11. Did you have any practical childcare support from family, friends or neighbours? Who? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>*</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neighbours</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes—Support Ask (a & b)
If No support ask (b)

(a) What support did they give? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>*</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason

(b) In total, how many hours a week of childcare support is provided by other people?
D12. When your children were under five years old how did you and your husband/wife/partner share childrearing responsibilities? (i.e. Who dressed, fed, took children to childminder; who took them out for leisure etc)

Code according to following

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solely does activity..........................</td>
<td>1</td>
</tr>
<tr>
<td>Majority of time does activity...</td>
<td>2</td>
</tr>
<tr>
<td>Half the time does the activity...</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes does activity........................</td>
<td>4</td>
</tr>
<tr>
<td>Never does activity............................</td>
<td>5</td>
</tr>
<tr>
<td>Not applicable.................................</td>
<td>9</td>
</tr>
</tbody>
</table>

Got children up and dressed in morning

Took children to nursery/childminder

Picked children up from nursery/childminder

Fed children in evening

Bathed children

Put children to bed

Took children out for leisure activities

Bought clothes for children

Took children to the doctors

Took time off work when children/nanny was ill

D13. Did you employ (other) outside domestic help when your children were under five years old? e.g. cleaning lady, gardener.

Yes ..........(Ask a).............................................1

No ..........(Go to OD14)......................................2

(a) How often did they come to the house?

Once a fortnight - full day ................................1

Once a fortnight - half day ................................2

One half day a week .......................................3

Two half days a week ....................................4

3 half days a week .......................................5

4 or more half days a week ............................6

Not applicable............................................9
D14. How did you and your first husband/wife/previous partner share household tasks when your children were under five years old?

Code according to following

<table>
<thead>
<tr>
<th>Activity</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing dishes/Loading dishwasher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ironing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decorating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D15. Did you or your husband/wife/partner go away for conferences at any time when your children were under five years old?

Yes, partner ............................................................1
Yes, Respondent .........................................................2
Yes, both .................................................................3
No, partner not able to because of domestic commitments (Go to OD16) 4
No, respondent not able to because of domestic commitments (Go to OD16) 5
No, partner does not wish to attend conferences ....................(Go to OD16) ....6
No, respondent does not wish to attend conferences...............(Go to OD16) ....7

(a) If Yes: How were childcare arrangements organised?
D16. Could you tell me at what stage in your career you married/remarried/began living with current partner? i.e. State grade

- At medical school ...........................................1
- PRHO .........................................................2
- SHO ............................................................3
- Registrar .......................................................4
- Senior Registrar ............................................5
- Consultant ......................................................6
- Associate Specialist .........................................7
- Staff Grade ....................................................10
- Clinical Assistant ..........................................11

I would now like to ask you some questions about your current marriage/partner.

GO TO SECTION C FOR QUESTIONS ON CURRENT PARTNER: BEGIN WITH QUESTION C3
**SECTION E  IF DIVORCED/WIDOWED**

E1. Could you tell me at what grade in your career you got married?

<table>
<thead>
<tr>
<th>Grade</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At medical school</td>
<td>1</td>
</tr>
<tr>
<td>PRHO</td>
<td>2</td>
</tr>
<tr>
<td>SHO</td>
<td>3</td>
</tr>
<tr>
<td>Registrar</td>
<td>4</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>5</td>
</tr>
<tr>
<td>Consultant</td>
<td>6</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>7</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Assistant</td>
<td>11</td>
</tr>
</tbody>
</table>

E2. Do you mind telling me when you were widowed/separated from your husband/wife (State grade)?

<table>
<thead>
<tr>
<th>Grade</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At medical school</td>
<td>1</td>
</tr>
<tr>
<td>PRHO</td>
<td>2</td>
</tr>
<tr>
<td>SHO</td>
<td>3</td>
</tr>
<tr>
<td>Registrar</td>
<td>4</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>5</td>
</tr>
<tr>
<td>Consultant</td>
<td>6</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>7</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Assistant</td>
<td>11</td>
</tr>
</tbody>
</table>

ONLY ASK DOCTORS WHO ARE DIVORCED/SEPARATED

E3. Do you think your career in medicine had any influence on your divorce/separation?

<table>
<thead>
<tr>
<th>Influence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Large effect</td>
<td>1</td>
</tr>
<tr>
<td>Some effect</td>
<td>2</td>
</tr>
<tr>
<td>No effect</td>
<td>3</td>
</tr>
</tbody>
</table>

(a) Do you mind telling me in what way?
E4. On average, when do you leave home in the morning and return in the evening during a normal working day?

- Before 8 a.m ........................................... 1
- Between 8 and 9 a.m .................................. 2
- After 9 a.m ............................................. 3
- Before 5 p.m ........................................... 1
- Between 5 p.m and 6 p.m .............................. 2
- After 6 p.m and before 7 p.m .......................... 3
- After 7 p.m ............................................. 4

(a) Do you work at weekends? Is this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

- On call at hospital/surgery ................................ 1
- On call at home ........................................ 2
- Working at home ....................................... 1
- Other employment outside the home ..................... 1

(b) How often is this?
- Every weekend ........................................ 1
- 1 in 2 .................................................. 2
- 1 in 3 .................................................. 3
- 1 in 4 .................................................. 4
- Less than 1 in 4 ...................................... 5

(c) On average, how many hours do you work a week at the hospital? Not applicable 99

(d) On average, how many extra hours do you work a week outside the hospital? Not applicable 99

I would like to ask you some questions about your marriage

E5. Was your husband/wife employed for the majority of the time you were married? (Code state of employment for the majority of the marriage)

- Employed part time .................................... 1
- Employed - full time .................................... 2
- Self employed .......................................... 1
- Unemployed ............................................ 2
- Housewife ............................................. 5
- Retired .................................................. 6

(a) What was his/her occupation?

(State occupation ......................................)

(b) What was his/her last occupation?

(State occupation ......................................)

E6. I asked for your work history because we are trying to gather a career and life history for each doctor. It would be helpful if I could gather information on your (first) husband/wife's career history from the time you met until when you were separated from your husband/were widowed. Would you mind helping me fill in these details [SHOW SHEET]
E7. To what extent did your husband/wife support you in your career progression?

A great deal of support (Ask a) ..........................................................1
Some support .......... (Ask a) ..........................................................2
Very little support ... (Ask c) ..........................................................3
Not at all ............ (Ask c) ..........................................................4

(a) Did he/she always give you this support?
Yes ................ (Ask d & e) ..........................................................1
No ................. (Ask b, c, d, e) ..........................................................2

(b) Could you please explain?

(c) How do you feel about this?

(d) In what ways did he/she support you? (Code Yes or No according to category)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional/moral support</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practical support</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other ways (Specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other ways:

(e) Did he/she support you when you had to work long hours?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>Rarely</td>
<td>3</td>
</tr>
</tbody>
</table>
E8. Do you have any children?

Yes: One ................................................................. 1
    Two ................................................................. 2
    Three ............................................................... 3
    Four ................................................................. 4
    Five or more ..................................................... 5

No ................................................................. 6

(a) How old are they? (Circle Yes or No if children in each category)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under two years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2-5 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11-16 years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Over 16 years</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Children Under Five Years: - GO TO QE9
If Children Under Five Years Plus Children Over Five: - GO TO QE9
If Children aged between Five and sixteen Years GO TO QE9
If all children over sixteen years GO TO QE20

If No children: (b) Was your career a contributory factor towards this?

   Yes ................................................................. 1
   No ................................................................. 2
   Not applicable .................................................. 9

(a) In what way?

GO TO SECTION F
E9. Do your children live with you?
   Yes. (Go to E10/E15) ......................................................... 1
   No. (Go to E27) ............................................................... 2

ASK DOCTORS WITH CHILDREN UNDER FIVE YEARS OLD/PLUS DOCTORS WITH CHILDREN UNDER FIVE AND OVER FIVE YEARS OLD.

E10. Who looks after your children when you are at work? (Preschool children and after school for older children) (Circle Yes or No for each category)

   Yes No
   Live in Nanny ............................................................... 1 2
   Nanny (not live in) ....................................................... 1 2
   Childminder ............................................................... 1 2
   Nursery/Nursery School ................................................ 1 2
   Day time care by relatives .......................................... 1 2
   Children at boarding school ........................................ 1 2
   Other (State) .............................................................. 1 2

State other reason

E11. Do you have any practical childcare support from (other) family, friends or neighbours? Who? (Circle Yes or No for each category)
   Yes No
   Friends ................................................................. 1 2
   Relatives ............................................................... 1 2
   Neighbours ............................................................. 1 2

   If Yes - Support Ask (a & b)
   If No - Support Ask (a)

   (a) What support do they give? (Circle Yes or No for each category)
       Yes No
       Babysitting ......................................................... 1 2
       Children stay with them during exam time .................... 1 2
       Children stay with them during holidays/half term .......... 1 2
       Available during an emergency .................................. 1 2
       Taking to/from School ............................................. 1 2
       Other (SPECIFY) ................................................... 1 2

   State other reason

   (b) In total, how many hours a week of childcare support is provided by other people?
E12. Do you currently employ outside domestic help? e.g. cleaning lady, gardener

Yes  (ASK A)  ................................................................. 1
No    (ASK B) ............................................................... 2

If Yes (a) How often do they/doe he/she come to the house?

Once a fortnight - full day  ............................................ 1
Once a fortnight - half day .......................................... 2
One half day a week ..................................................... 3
Two half days a week .................................................. 4
3 half days a week ....................................................... 5
4 or more half days a week ........................................... 6
Not applicable ............................................................. 9

If No: (b) Have you employed any outside domestic help in the past?

Yes ................................................................. 1
No ................................................................. 2
Not applicable .......................................................... 9

Only ask if doctor has paid help

E13. How important is it for you to employ practical help with household tasks?

Very important ......................................................... 1
Important .............................................................. 2
Not very important ..................................................... 3
Don’t Know ............................................................. 8

E14. Do you go away from home for conferences at any time?

Yes  ...........................................(Ask A)  ......................... 1
No, respondent not able to because of domestic commitments  (Go to OE27) ................. 2
No, respondent does not wish to attend conferences ........ (Go to OE27)  ................. 3

(a) How are childcare arrangements organised?

GO TO QUESTION E27
ASK DOCTORS WITH CHILDREN FIVE TO SIXTEEN YEARS OLD

E15  Who looks after your children after school when you are at work? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent at home when children return</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Live in Nanny</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nanny (not live in)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Childminder</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursery/ Nursery School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Day time care by relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children at boarding school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other person

E16. Do you have any practical childcare support from family, friends or neighbours? Who? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbours</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes-Support ask (A & B)
If No-Support ask (B)  

(a) What support do they give? (Circle Yes or No for each category)  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babysitting</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during exam time</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children stay with them during holidays/half term</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available during an emergency</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Taking to/from School</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

State other reason

(b) In total, how many hours a week of childcare support is provided by other people?

Not applicable............99
I would like to ask you some questions about when your children were under five years old.

Refer to Work History Sheet, if information not already collected ask:

E20. Did you and your husband/wife both work full time when your children were under five years old?

Both worked full time .................................................1
Respondent worked full time, partner worked part time ..................2
Respondent worked part time, partner worked full time .................3
Respondent worked full time, partner didn’t work .........................4
Respondent didn’t work, partner worked full time ........................5
**ASK IF RESPONDENT WORKED WHEN CHILDREN WERE YOUNG**

**E21.** On average, when did you leave home in the morning and return in the evening during a normal working day when your children were under five years old?

<table>
<thead>
<tr>
<th>Time</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 8 a.m.</td>
<td>1</td>
</tr>
<tr>
<td>Between 8 and 9 a.m</td>
<td>2</td>
</tr>
<tr>
<td>After 9 a.m.</td>
<td>3</td>
</tr>
<tr>
<td>Before 5 p.m.</td>
<td>1</td>
</tr>
<tr>
<td>Between 5 p.m. and 6 p.m</td>
<td>2</td>
</tr>
<tr>
<td>After 6 p.m. and before 7 p.m.</td>
<td>3</td>
</tr>
<tr>
<td>After 7 p.m.</td>
<td>4</td>
</tr>
</tbody>
</table>

(a) Did you work at weekends? Was this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(b) How often was this?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every weekend</td>
<td>1</td>
</tr>
<tr>
<td>1 in 2</td>
<td>2</td>
</tr>
<tr>
<td>1 in 3</td>
<td>3</td>
</tr>
<tr>
<td>1 in 4</td>
<td>4</td>
</tr>
<tr>
<td>Less than 1 in 4</td>
<td>5</td>
</tr>
</tbody>
</table>

(c) On average, how many hours a week did you work in the hospital when your children were under five years old?

Not applicable...99

(d) On average, how many extra hours a week did you work outside the hospital when your children were under five years old?

Not applicable...99

**ASK IF PARTNER WORKED WHEN CHILDREN WERE YOUNG**

**E22.** On average, when did your husband/wife leave home in the morning and return in the evening during a normal working day when your children were under five years old?

<table>
<thead>
<tr>
<th>Time</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 8 a.m.</td>
<td>1</td>
</tr>
<tr>
<td>Between 8 and 9 a.m</td>
<td>2</td>
</tr>
<tr>
<td>After 9 a.m.</td>
<td>3</td>
</tr>
<tr>
<td>Before 5 p.m.</td>
<td>1</td>
</tr>
<tr>
<td>Between 5 p.m. and 6 p.m</td>
<td>2</td>
</tr>
<tr>
<td>After 6 p.m. and before 7 p.m.</td>
<td>3</td>
</tr>
<tr>
<td>After 7 p.m.</td>
<td>4</td>
</tr>
</tbody>
</table>

(a) Did he/she work at weekends? Was this on call at hospital/on call at home/working at home? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call at hospital/surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>On call at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Working at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other employment outside the home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
(b) How often was this?
Every weekend..............................................1
1 in 2 .........................................................2
1 in 3 .........................................................3
1 in 4 .........................................................4
Less than 1 in 4 .............................................5

(c) On average, how many hours a week did your husband/wife/partner work at their place of work when your children were under five years old? Not applicable...99

(d) On average, how many extra hours a week did your husband/wife/partner work outside their place of work when your children were under five years old? Not applicable....99

ONLY ASK IF RESPONDENT WORKED WHEN CHILDREN WERE UNDER FIVE YEARS OLD

E23. When your children were under five years old who looked after them when you were at work? Yes No

Livin Nanny ..................................................1 2
Nanny(not live in) (Ask A) ..................................1 2
Childminder (Ask A) .........................................1 2
Nursery/Nursery School (Ask A) ............................1 2
Day time care by relatives (Ask A) ........................1 2
Partner ................................................................1 2
Children at Boarding School..................................1 2

E24. Did you have any practical childcare support from family, friends or neighbours? Who? Yes No

Friends ................................................................1 2
Relatives ...........................................................1 2
Neighbours .........................................................1 2

If Yes-Ask (a & b)
If No support Ask (b)

(a) What support did they give? Yes No

Babysitting .......................................................1 2
Children stay with them during exam time ...............1 2
Children stay with them during holidays/half term ......1 2
Available during an emergency ................................1 2
Taking to/from School ..........................................1 2
Other (SPECIFY) ..................................................1 2

State other reason

(a) How many hours a week of childcare support were provided by other people? Not applicable...........99
E25. When your children were under five years old how did you and your husband/wife/ share childrearing responsibilities? (ie. Who dressed, fed, took children to childminder; who takes them out for leisure etc)

Code according to following

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Solely did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Majority of time did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Half the time did the activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sometimes did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Never did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got children up and dressed in morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took children to nursery/childminder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picked children up from nursery/childminder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fed children in evening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathed children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put children to bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took children out for leisure activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bought clothes for children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took children to the doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took time off work when children/nanny was ill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E26. How did you and your husband/wife share household tasks when your children were under five years old?

Code according to following

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Solely did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Majority of time did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Half the time did the activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sometimes did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Never did activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>R</th>
<th>P</th>
<th>PC</th>
<th>IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing dishes/Loading dishwasher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ironing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decorating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E27. In your opinion, has having a family had any effect on your career progression?
Yes - good effect. .................................................................1
Yes - bad effect .................................................................2
No effect .................................................................1

If Yes: (a) In what way?

E28. Do you think your career progression has had any effect on your family life?
Yes - good effect .................................................................1
Yes - bad effect .................................................................2
No effect .................................................................1

If Yes: (a) In what way?
SECTION F POSTGRADUATE TRAINING

I would now like to ask you some questions about your postgraduate medical training.

F1. During your training as a junior doctor were there any jobs which may have progressed your career further but you were unable to take because it meant moving areas?

Yes ........(Ask a).................................................................1
No........(Go to OF2)...........................................................2

(a) Why were you unable to move?

(b) Could you tell me what happened?

F2. As you know a medical career involves completing research, looking at your CV I can see you have undertaken research in the past, do you think you have had enough opportunity to carry out research in the past?

Plenty of opportunity ........(Ask b)...........................................1
Enough opportunity ........(Ask b).............................................2
Not enough opportunity ........(Ask a & b)....................................3

(a) Why have you not had enough opportunity?
(b) What are your views about the need for a doctor in your specialty to undertake research?
F3. In your career so far have you at any time experienced difficulties in being promoted from one grade to another? If Yes: What grade(s) did you have difficulty transferring to? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREO-SHO</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SHO-Registrar</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Registrar-Senior Registrar</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Senior Registrar-Consultant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Registrar-Staff Grade</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Senior Registrar-Associate Specialist</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes:
(a) What do you think were the reasons for this?

(b) What did you do?

F4. Have you had anybody who was particularly helpful in furthering your career? (Circle Yes or No for each category)

<table>
<thead>
<tr>
<th>Helpfulness</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: Female Consultant (ASK B &amp; C)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Male Consultant (ASK B &amp; C)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other person (ASK A &amp; B)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No. (GO TO Q5)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(a) Who was this person?

IF YES:
(b) How did they help?
(c) Do you think this made any difference to the success of your career?

<table>
<thead>
<tr>
<th>Effect on Career Progress</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large effect on career progress</td>
<td>[Ask d]</td>
<td>[Ask d]</td>
</tr>
<tr>
<td>Some effect on career progress</td>
<td>[Ask d]</td>
<td>[Ask d]</td>
</tr>
<tr>
<td>Neither good or bad effect on career</td>
<td>[Ask OF5]</td>
<td>[Ask OF5]</td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(d) In what way?

F5. Have you found the medical career structure restricted you in any way from achieving what you wanted to do professionally?

<table>
<thead>
<tr>
<th>Restriction</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>[Ask a]</td>
</tr>
<tr>
<td>No</td>
<td>[Go to OF6]</td>
</tr>
</tbody>
</table>

If Yes: (a) In what way?  Probe: Could you explain?

F6. What was the average number of hours a week you worked during your higher specialist medical training? (Higher specialist training = registrar/senior registrar)

<table>
<thead>
<tr>
<th>Hours</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>72 hours or under</td>
<td>[Ask a]</td>
</tr>
<tr>
<td>Between 72 hours and 84 hours</td>
<td>[Ask a]</td>
</tr>
<tr>
<td>85 hours and over</td>
<td>[Ask a]</td>
</tr>
</tbody>
</table>
F7. What was the effect of working long hours on your life outside medicine, when you were a junior doctor?
F8. Do you think long working hours has any effect on a doctors' ability to develop and maintain steady relationships?

Yes .........................................................1
No ...........................................................2
Don't know ..............................................3

If Yes: (a) From a personal viewpoint is that something you experienced yourself?

Yes ..........................................................1
No .............................................................2

ASK FOR SINGLE DOCTORS ONLY:

(b) Have you cohabited or had any long term relationships in the past?

Yes ..........................................................1
No .............................................................2
Not applicable ................................_________9

(c) I asked for your work history because we are trying to gather a career and life history for each doctor. It would be helpful if I could gather some information about the career history of your partner. Do you mind helping me fill in these details. (SHOW SHEET)
SECTION G ENVIRONMENT IN MEDICAL PROFESSION

I would now like to ask you some questions about the environment within the medical profession at the time you were training.

G1. What was the proportion of male to female consultants in your speciality at the place you trained as a registrar? (Ask for estimate if specific numbers not known. Clarify male and female proportions)

G2. What was the proportion of male to female registrars in your speciality at the place you trained as a registrar? (Ask for estimate if specific numbers not known. Clarify male and female proportions)

G3. What was the attitude of consultants towards women doctors during your higher specialist training? (Probe: Did they have any views about the type of work men and women should perform? Did they have any views about the typical characteristics of male and female doctors?) (Higher specialist training refers to registrar/senior registrar training)
G4. During your higher specialist training, did you at any time feel that there was a "correct" way of behaving if you wanted to progress in your speciality?

Yes ......(ask a & b).................................................................................1
No ......(Go to QH1)......................................................................................2
Don’t know  (Go to QH1) ..............................................................................3

If Yes: (a) In what way?

(b) How did you feel about this?
Finally I would like to ask you some questions about medical achievement

H1. How satisfied are you with your achievement in your medical career so far?
   Very satisfied .........................................................1
   Satisfied ...........................................................2
   Fairly Satisfied .....................................................3
   Not Satisfied .......................................................4

   (a) Could you please explain?

H2. If you were able to start your medical career again, is there anything you would change, second time around?
H3. Now that you have reached consultant grade do you have any career aspirations for the future?
H4. Finally, is there anything which we haven't talked about, which has been influential in the success of your medical career?
(b) How do you feel about this?

GO TO SECTION F
Dear Dr

I am currently undertaking a piece of research for South Thames Regional Health Authority on the Occupational Achievement and Career Patterns of Doctors in Hospital Medicine. The study aims to explore why doctors of the same age reach different grades in hospital medicine and how organisational processes and the doctors position in the family unit affect occupational achievement. The results of the research will be used to inform future policy to improve working practices for doctors in the NHS.

The study involves interviewing a representative sample of male and female doctors born between 1st January 1945 and 31st December 1955 who are currently working in NHS hospitals in the South Thames Region. I am writing to ask if it is possible to interview you. It is important that you take part, so that an accurate picture of doctors' views can be obtained. The interview would take a maximum of one hour and everything you say will be completely confidential.

If you have any questions about the research please do not hesitate to contact me.

Yours sincerely

Carol Dumelow
Research Fellow
**WORK AND LIFE HISTORY - RESPONDENT**

<table>
<thead>
<tr>
<th>ID</th>
<th>GRADE</th>
<th>SPECIALITY</th>
<th>SEX</th>
<th>PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESP Year</td>
<td>Grade</td>
<td>Speciality</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FT/PT</th>
<th>M/S/C</th>
<th>Home/Child</th>
<th>PARTNER</th>
<th>Home/Place</th>
<th>FT/PT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Job</td>
<td>Speciality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

M=Married  S=Single  C=Cohabiting  D=Divorced  W=Widowed  SP=Separated  R=Long Term Relationship

**APPENDIX FOUR**
**Chart 13: Part Time Work**

*Female Consultants*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11. Differential achievement of distinction award by type of work/family relationship adopted by consultants

<table>
<thead>
<tr>
<th></th>
<th>Career Dominant</th>
<th>Segregated</th>
<th>Accommodating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Distinction Award</td>
<td>1 (33)</td>
<td>2 (12)</td>
<td>19 (27)</td>
</tr>
<tr>
<td>No Distinction Award</td>
<td>2 (66)</td>
<td>15 (88)</td>
<td>52 (73)</td>
</tr>
<tr>
<td>Total</td>
<td>3 (100)</td>
<td>17 (100)</td>
<td>71 (100)</td>
</tr>
</tbody>
</table>

Chi-square=0.10 NS

Women consultants who adopted an *accommodating* work/family relationship were least likely to have achieved a distinction award (9%) compared with women consultants who adopted a *segregated* work/family relationship who were most likely to have achieved a distinction award (16%). Male consultants with a *career dominant* work/family relationship were most likely to have a distinction award (33%) (Table 11). Although some variation exists there is no significant association between type of work/family relationship and achievement of a distinction award.

In contrast, there was greater association between type of hospital post held and type of work/family relationship adopted by women consultants (Table 12). Nearly a third (29%) of women consultants with a *career dominant* work/family relationship compared to only 17% of women consultants who adopted an *accommodating* work/family relationship held teaching hospital consultant posts.

APPENDIX SEVEN
Table 12. Type of consultant post held by type of work/family relationship adopted by consultants

<table>
<thead>
<tr>
<th>Type of Post Held</th>
<th>Career Dominant</th>
<th>Segregated</th>
<th>Accommodating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male  No. %</td>
<td>Female No. %</td>
<td>Male No. %</td>
</tr>
<tr>
<td>Teaching Hospital</td>
<td>0 (0)</td>
<td>5 (29)</td>
<td>17 (23)</td>
</tr>
<tr>
<td>District General Hospital</td>
<td>3 (100)</td>
<td>12 (71)</td>
<td>56 (77)</td>
</tr>
<tr>
<td>Total</td>
<td>3 (100)</td>
<td>17 (100)</td>
<td>73 (100)</td>
</tr>
</tbody>
</table>