The feminisation of the medical profession in England: implications and responses

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

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ABSTRACT

This thesis aims to understand the implications of, and responses to, the recent feminisation of the medical profession in England, through exploring the changes in the employment and careers of doctors and their relationship, if any, to this change of the workforce. Four main contextual issues are evident that are unique to the medical profession. First, there is gender segregation across medical specialties. Second, medicine is traditionally seen as an elite status profession within society. Third, the profession is characterised by long working hours and a high number of years dedicated to training. Fourth, the profession is largely under the monopsony of the NHS, thus bound to the public sector during a period of economic austerity. Moreover, unexpectedly prior to conducting the research, the state’s changes to the junior doctors’ contract led to industrial action, thus adding another dynamic to the research context. The thesis seeks to explore these four key areas within a feminising profession, addressing four questions: 1) what shapes gender segregation, and is it becoming further entrenched following feminisation; 2) has the profession experienced devaluation following feminisation; 3) how do long working hours shape the employment experiences of doctors; and 4) how do the roles of the state play a part in shaping the employment experiences of doctors? The research addresses the overarching research aim and questions through analysing the employment experiences of doctors from anaesthetics, general practice and paediatrics across three key points of the medical career trajectory. The research takes a simple mixed methods approach by employing a questionnaire, in-depth semi-structured interviews, and content analysis of secondary data. To ensure the views of a wide range of actors are included, the research sample includes specialty trainees, consultants, salaried GPs, GP Partners, Training Programme Directors, BMA and Royal College Officials and a Practice Manager. The findings show there are gendered reasons for medical specialty choices, and also reveal that there is evidence to suggest potential devaluation of the medical profession, although it is too early to see the full extent of this. The extreme model of working time in medicine greatly influences the employment experiences of doctors, in terms of their career choices; work-life-balance; and pay. Finally, it appears largely the role(s) of the state, through its interventions (and lack of) further entrench gender segregation; contribute to possible devaluation; and exacerbates the employment experiences of doctors. The research findings contribute to four areas of discussion. First, it appears the roles of the state (through the availability of LTFT training) and Royal Colleges (through training programme organisation) are creating ‘diversionary pathways’ that lead women to medical specialties that are perceived as being more conducive to family life, which leads to a new theoretical framework to help explain horizontal gender segregation within medicine. Second, the suggestion of devaluation has been largely driven by the state, particularly through proposed changes to the junior doctors’ contract. Thirdly, the medical profession is an example of hybrid model of results-based and standard working time that creates an extreme male breadwinner model of working time. Fourthly, the research brings to the fore the importance of the role of the state as the deliverer of a public service. The research also provides potential employment policy recommendations within these areas, and directions for future research of other medical specialties and feminising professions.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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<td>ACCEA</td>
<td>Advisory Committee on Clinical Excellence Awards</td>
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<td>ACCS</td>
<td>Acute Care Common Stem</td>
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<td>AKT</td>
<td>Applied Knowledge Test</td>
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<td>ARM</td>
<td>Annual Representatives Meeting</td>
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<td>ASHE</td>
<td>Annual Survey of Hours and Earnings</td>
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<td>BAME</td>
<td>Black, Asian and minority ethnic</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>CCT</td>
<td>Certificate of Completion of Training</td>
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<td>CEA</td>
<td>Clinical Excellence Award</td>
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<td>Clinical Skills Assessment</td>
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<td>CT</td>
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<td>DDRB</td>
<td>Doctors’ and Dentists’ Review Body</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>EHRC</td>
<td>Equality and Human Rights Commission</td>
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<td>EWTD</td>
<td>European Working Time Directive</td>
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<td>FRCA</td>
<td>Fellowship of the Royal College of Anaesthetists</td>
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<td>FY</td>
<td>Foundation Year</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HRA</td>
<td>Health Research Authority</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>Income Data Services</td>
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<td>IMG</td>
<td>International Medical Graduate</td>
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<td>LTFT</td>
<td>Less Than Full-Time</td>
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<td>MRCPCH</td>
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<td>MWF</td>
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<td>NDPB</td>
<td>Non-Departmental Public Body</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<tr>
<td>RCPCH</td>
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<tr>
<td>SAS</td>
<td>Specialty and Associate Specialist</td>
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<td>Sp</td>
<td>Specialty post</td>
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<td>TPD</td>
<td>Training Programme Director</td>
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<td>TUC</td>
<td>Trade Union Congress</td>
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<td>WLB</td>
<td>Work-life-balance</td>
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<td>Work Place Based Assessment</td>
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CHAPTER ONE
INTRODUCTION

INTRODUCTION
The UK labour market as a whole has become increasingly feminised, with women now accounting for 47% of the total employed workforce (ONS, 2018a). Women are also more likely to work part-time compared to men, with 41% of employed women working part-time compared with just 13% of employed men in the UK (ONS, 2018a). In addition, the UK’s public sector has played a key role in the integration of women into work since the second world war (WW2) (Rubery, 2013) and remains a long-standing employer of a predominantly female workforce, as approximately two thirds of the public sector workforce is female, compared to just 40% in the private sector (Cribb et al, 2014). Even though ‘women’s work’ has typically been associated with low paid, low status work – characterised by temporary and/or part-time employment (Warren and Lyonette, 2015; 2018) – over the last twenty to thirty years there has been a shift whereby high-status, male dominated professions have become, and are becoming, increasingly feminised, in areas such as: law, accountancy, veterinary medicine, and medicine (Bolton and Muzio, 2008; Tomlinson et al, 2013; Lewis, 2007; Clarke and Knights, 2018; Crompton and Lyonette, 2011). However, the theory of devaluation (England, 1992; Reskin and Roos, 1990; Crompton and Sanderson, 1990) argues that once women enter a profession, the profession becomes devalued in terms of status, salary and job security. Research has also found that when women do enter male-dominated professions/occupations, they become segregated in lower status areas, and lower hierarchical levels, of the profession/occupation (Reskin and Roos, 1990; Crompton and Sanderson, 1990). In some cases it has been found that men in male-dominated professions use “defence mechanisms” to prevent women from reaching the more prestigious areas, and higher levels of a profession (Bolton and Muzio, 2008).

As more women have been entering professions, usually characterised by long working hours; high levels of expertise and autonomy (Cruess et al, 2004), working time trends
have also changed in two key ways. The first is that work life balance and flexible working practices have come to the fore, but often to the benefit of the employer to have a more flexible workforce that suits a growing ‘24/7-service’ culture (Fleetwood, 2007; Rubery et al, 2005a; Özbilgin et al, 2011). The second is that working time is becoming more results-based, where working time is characterised as ending when a job is completed, unlike the standard model where working time is scheduled (Rubery et al, 2005). However, despite men taking more of an interest in child-friendly working practices (Gatrell et al, 2014), women still hold the majority of childcare responsibilities within the home (Lyonette and Crompton, 2015), which makes employment under the results-based model problematic. For women who strive to achieve a profession-based work life that is compatible with a family life, there is little option but to work part-time hours, which has been found to limit their career progression, their training opportunities and subsequently their pay (Smithson et al, 2004; Bolton and Muzio, 2008; Lewis, 2007; Walsh, 2012).

The employment area that this thesis is concerned with is the medical profession. The term ‘profession’ is used distinctively from ‘occupation’ throughout this thesis. This is because professions are significantly different to occupations, and there has been much academic debate surrounding what distinguishes a profession from an occupation (Drudy, 2008). Although Crompton and Sanderson (1990, page 66) argue that qualifications and professions are not “homogenous entities”, professions can be considered to be distinct as they require a high level of expertise and specific, usually non-transferable qualifications, where “skills are acquired as a consequence of professional training and transfer of knowledge rather than from day-to-day experiences accessible to all” (Crompton and Sanderson, 1990, page 67). However professions are not distinct solely because of expert qualifications and skills as there are other facets to the definition of “profession”. Cruess et al (2004) have explored these facets further in the context of the medical profession. They recognise that to encompass all professions, such as law, accountancy and architecture, the definition of ‘profession’ needs to be broad yet specific. Therefore Cruess et al (2004) provide the following definition of ‘profession’:
“An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation” (Cruess et al, 2004, page 75).

This definition of ‘profession’ appears appropriate to use throughout this thesis as it encapsulates the importance of expert qualifications defining a profession, alongside other key attributes of autonomy and self-regulation, that the literature on professions tends to overlook.

When the profession is set within the UK public sector, another dimension may be added to this issue. The state has numerous roles, not only as the employer of the public sector workforce but also as an economic manager and employment legislator (Hyman, 2008). On the one hand the state strives to be perceived as the ‘model employer’, but on the other hand it may fail to act in this way as capitalist logic prevails, particularly during times of economic austerity (Hyman, 2008; Coffey and Thornley, 2009; Conley and Page, 2018). Over the last 30-40 years, the state has become increasingly neoliberal in its philosophies and subsequent actions, particularly towards the public sector. As a result there has been an increased adoption of employment practices similar to those seen in the private sector. Due to the public sector having a predominantly female workforce (Cribb et al, 2014), women have often suffered most from the negative impacts of these employment terms and conditions, both in professions and lower level jobs (Conley and Jenkins, 2011; Conley et al, 2011). Moreover, in terms of welfare provisions, under austerity the state cut back again on childcare, just as there had been some improvements in provision from a low level in the 2000s.
The focus of this research is the feminisation of the medical profession, set in a context of a largely public sector bound profession that has traditionally been a white, male dominated profession, characterised by a culture of long working hours and high workloads (Balme et al, 2015). In 1960, men made up an overwhelming 76% of the medical school intake in the UK (Centre for Workforce Intelligence, 2012). However, the number of women entering medical school in the UK is now higher than men, with 58% of medical students being female (General Medical Council, 2017a). Despite an increase in female doctors over the last fifteen years, statistics show there is both horizontal and vertical gender segregation in medicine (NHS Digital, 2018a).

Currently, little is known about how the increased proportion of women entering the medical profession is shaping the medical profession within the NHS. The focus of this research is not why the medical profession has become feminised, as it is the medical schools within universities that play a key role in determining the number of female medical students who then go on to practice medicine. Instead, this research aims to explore the employment experiences of doctors, post foundation training, and the implications, and responses to, the feminisation of the profession.

Exploring the gendered experience of doctors is therefore central to this work, but gender is not studied in isolation. Feminist and gender studies literatures suggest that other personal characteristics, such as ethnicity, age and sexual orientation should also be considered when researching employment relations (Crenshaw, 1989; Hancock et al, 2007). Where appropriate, this research recognises diversity amongst and within groups of male and female doctors and attempts to be “intersectionally sensitive” (McBride et al, 2015).

**RESEARCH AIM AND QUESTIONS**

The primary aim for this research is to explore the implications of, and responses to, the feminisation of the medical profession in England. This aim is addressed through the following four research questions:

**Research question one:** how is gender segregation being produced in the medical
profession, and what are the key factors in shaping this gender segregation?

**Research question two:** Has the feminisation of the medical profession led to the devaluation of the profession, and/or areas of the profession, in terms of professional status, pay and job security?

**Research question three:** How has working time shaped the employment experiences of doctors within the context of a feminising workforce, and to what extent has a feminising workforce shaped attitudes, and responses, towards working time arrangements within the medical profession?

**Research question four:** What are the roles of the state, and other institutions with influence over the employment relationship, in shaping the employment experiences of doctors within a feminising workforce?

**THESIS STRUCTURE**

Chapter two, the literature review, brings together four main bodies of literature that relate to the research questions. The first concerns gender segregation, and that women work in occupations, and areas of professions, that are of lower pay and status (Crompton and Sanderson, 1990; Reskin and Roos, 1990). Secondly, the feminisation literature focuses on debates around the theory of devaluation (England, 1992; Kilbourne et al, 1994; Magnusson, 2009), that when a profession becomes feminised, the salary, status and security diminish. The third area of literature concerns working time, first by exploring recent working time trends and second by looking more closely at working time within professions. The fourth area looks at the roles of the state, and its employment of women, since medicine is under the monopsony of the NHS, thus bound to the public sector. Chapter three, the context chapter, explains the complex institutional backdrop where this research takes place, including the organisation of medical labour, the organisation of medical training programmes, doctors’ employment terms and conditions and the roles of the state regarding the employment of doctors. Next, chapter four outlines and justifies the methodology adopted in this research, as well as the ethical considerations and potential research
limitations. The findings chapters (five, six and seven) cover the main stages of the typical career trajectory for doctors from foundation stage onwards. Chapter five presents findings on the reasons for medical specialty choices drawing on a survey of 226 specialty trainees, and interviews with 30 specialty trainees from anaesthetics, general practice and paediatrics from the same HEE region in England to distinguish how gender may shape specialty choices. Chapter six presents findings on specialty trainees’ employment experiences during their training programme, in terms of their work-life-balance; career progression; pay and perceptions of the profession’s status. This chapter draws mainly on 30 interviews with specialty trainees from anaesthetics, general practice and paediatrics; and also three interviews with Training Programme Directors (TPDs) from these three medical specialties. Chapter seven presents findings on the employment experiences of those at the highest levels of the medical career hierarchy, again focussing on issues surrounding work-life-balance, pay, and the profession’s status. This chapter is informed by six interviews, with consultant anaesthetists and paediatricians from the same NHS Trust; two salaried GPs, two GP Partners and a Practice Manager. In addition, senior interviews with six Royal College and BMA officials supplement the findings in chapters six and seven. Chapter eight, the discussion chapter, brings together the findings from the three empirical chapters and considers the contributions of the research in the light of the extant literature discussed in chapter two. Finally, chapter nine concludes this thesis, by highlighting the research contributions and suggests potential avenues for further research in this area.
CHAPTER TWO
LITERATURE REVIEW

INTRODUCTION
This chapter is comprised of five main sections. These represent the key areas of literature identified for this research that aims to explore the implications of, and responses to, the feminisation of the medical profession, through the understanding of the employment experiences of doctors. The first section concerns gender segregation and the feminisation of male-dominated professions. It explores the argument in the literature that gender segregation may re-emerge when women enter male-dominated professions, as they tend to become both horizontally and vertically segregated, working in the lower paid and/or lower status areas of the profession, and at the lower levels of the organisation hierarchy (Reskin and Roos, 1990; Crompton and Sanderson, 1990). The second section explores the implications of feminisation, particularly the theory of devaluation (England, 1992; Kilbourne et al, 1994) that hypothesises that once a profession/occupation becomes feminised then the salary, status, and security of that profession/occupation diminish. The feminisation literature draws a link between occupational segregation/devaluation and working time in the sense that working time is a key determinant of women’s position within a profession, both horizontally and vertically. In addition, these areas of a profession where women usually work become devalued, in terms of pay and status. The third section of literature in this review looks at working time, first by looking at the general trends in working time in the UK, followed by a more detailed look at working time in professions and the implications of working time on female professionals. Due to the medical profession being largely bound to the public sector, the fourth section of this chapter focuses on the roles of the state, not only as the employer of the public sector, but also as the controller of public spending, employment regulations and its equality duty. This section also looks at how the earlier sections concerning gender segregation, devaluation and working time are conceptualised in the context of the public sector. Bringing these four key areas of literature together, this chapter ends with section five,
which applies the debates within these areas in relation to the medical profession to assist in formulating research questions and the methodological approach.

**SECTION ONE: GENDER SEGREGATION AND THE FEMINISATION OF PROFESSIONS**

In the UK, the gendered division of labour has been documented since the early seventeenth century and has continuously reshaped, and changed, throughout the centuries to the present day. Traditionally women’s assumed responsibility was within the home, so “the majority of women spent long periods of their adult lives either out of the labour force, or working part-time” (Crompton, 1997). Women that did work, usually unmarried women, did not have access to jobs that enabled them to live independently so they worked in roles of lower pay, status and job security. Therefore women’s dominant role within the home restricted their ability to fully participate in the labour market. In contrast, men were likely to work in manual or professional roles, where they often earned a higher ‘family wage’\(^1\) and had job security, so also had the ability to accumulate a pension (Crompton, 1997). However, the period after the Second World War saw more women enter the UK labour market (Crompton and Sanderson, 1990), particularly into the public sector (Rubery, 2013). During this time women continued to enter jobs of low pay and status, for example clerical work and jobs that reflected women’s typical roles within the home, such as cooking, cleaning and caring (Crompton and Sanderson, 1990), and men continued to dominate jobs of higher pay and higher status, particularly professions, such as medicine and law. Thus continuing the marked gender divisions of labour in the UK.

Although women still occupy the majority of low paid and low status jobs, women have recently made inroads into previously male-dominated professions over the last 20-30 years, in areas such as law (and medicine (The Law Society Annual Statistics Report, 2018a; GMC, 2017a). Women’s access to education has increased qualification

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\(^1\) During the 19th Century, men were paid a ‘family wage’ to enable them to provide financially for both their wife and children (Crompton, 1997).
levels amongst women since the latter part of the 20th Century (Crompton and Sanderson, 1990), as well as women having an increased “desire for greater economic independence” (Rubery and Grimshaw, 2003, p. 103) has allowed women to enter male-dominated professions more easily.

When women are clustered in certain occupations or professions, which tend to be of lower status, pay and security compared to male-dominated areas of work, this is referred to as ‘horizontal gender segregation’, whereas the clustering of women in the lower echelons of the hierarchy within an organisation is referred to as ‘vertical gender segregation’. There have been numerous theories regarding why gender segregation occurs, mostly based around the two main arguments of whether it happens as a result of women’s own, freely made choices to work within these areas, referred to as ‘preference theory’ (Hakim, 2006), or whether patriarchal, structural constraints created by institutions constrain women to certain occupations and professions (Walby, 1988). These theories are critically discussed within this section.

One theory that explains gender segregation is ‘human capital theory’, which argues that women are in lower paid jobs because they have lower ‘human capital’, in the form of fewer qualifications and less work experience, than men. Advocates of human capital theory argue that women choose jobs where they can earn the highest salary for their skill set, whilst also accommodating for fluctuations in their working patterns, for example to take time off work to have a baby. Crompton and Sanderson (1990, p. 161) look at the feminisation of pharmacy, which “bestows equivalent human capital upon those individuals who qualify to practice it”. Despite this, Crompton and Sanderson (1990) find that men dominate community pharmacy due to the lucrative opportunities to set up their own independent outlet, whereas women are clustered into hospital pharmacy where these opportunities are not available. This raises the question of whether the human capital theory can sufficiently explain the gender segregation of other highly skilled, previously male-dominated professions such as law and medicine? Also, human capital theory does not take into account how a prospective organisational ‘culture’ can shape women’s choices, nor does it consider institutional effects, since the theory is “based on the assumption that people act as a
consequence of rational calculations of economic benefit” (Walby, 1988, page 16). Cultural theorists suggest “people choose jobs which are in line with their beliefs to an appropriate masculine or feminine behaviour” (Walby, 1988, page 16). One cultural reason for segregation is based around ‘traditions’, particularly individuals’ positions within the family and the ‘sex-typing’ of jobs. Matthaei (1982) in Walby (1988, page 17) states that “new jobs are constructed as suitable for men or women...[and] are maintained because individuals have a strong interest in maintaining their identity as either masculine or feminine”.

A similarity of both human capital theory, preference theory, and the cultural theories is that they suggest women rationally and freely choose their own occupation or profession. There is no expectation of any discriminatory actions by organisations or the government occurring outside of the individual’s control that may be the cause of gender segregation. In contrast, ‘dual systems theory’ does suggest there is unfairness that causes segregation. Walby (1988, page 22) defines dual systems theory as “the intersection of the two systems of capitalism and patriarchy, from which dominants from each system, capitalists and men, benefit”. Blackburn et al (2002) argue that only vertical segregation entails inequality, whereas horizontal segregation expresses difference without the inequality. However, if where women are clustering is in jobs that on some indications might appear similar to a cluster of male occupations - for example in terms of human capital requirements - it may be the case that the women’s jobs cluster is both lower paid and accorded lower social status. Where this occurs there is an element of inequality, but it may not necessarily be as a result of direct discrimination. As these theories show, there are many conflicting explanations for gender segregation. It may be the case that aspects of each are applicable depending on the context, not only in terms of occupational context but also the sector, the country and the time of the research, since state policies may have an influence.

The feminisation of employment can be defined either as a process whereby a significant number of women enter a male dominated occupation, or profession, at a greater rate than men. It can also describe an occupation, or profession, where the overall majority of the workforce is clearly female (Crompton and Sanderson, 1990;
As mentioned earlier, over the last few decades, many male-dominated professions have now become notably feminised, but this has happened at differing rates. For example, professions such as teaching and pharmacy have been female dominated for a number of decades (Crompton and Sanderson, 1990 in the UK; Reskin and Roos, 1990 in the US), whereas other professions, such as medicine and law, are currently experiencing the process of feminisation. For example, the most recent Law Society Annual Statistics Report (2018) shows that the number of female practicing solicitors outnumbers male solicitors for the first time in history, and this looks set to continue as over two thirds of UK students who applied to study law at undergraduate level in 2016-17 were female. Similarly, the number of female doctors has also increased over the last ten years and now 47.5% of licensed doctors are women (GMC, 2017a). The feminisation of medicine looks set to continue, as 58% of doctors in training are female (GMC, 2017a). Those professions that have been female-dominated for a number of years, such as teaching and nursing, are often referred to as “women’s professions”, a term that further distinguishes the differences between occupations and professions - insinuating that ‘women’s professions’ are of higher status than occupations but remain lower than professions more generally (Crompton and Sanderson, 1990). In contrast, long-established male-dominated professions, such as medicine and law, are of the highest professional status (Bolton and Muzio, 2008).

Research suggests that the term ‘feminisation of professions’ has negative connotations (Skelton, 2002; Muzio and Bolton, 2006, Francis, 2000). Skelton (2002) looked at the feminisation of primary school teaching and found that the term ‘feminisation’ was viewed as a worrying trend that should be reversed. Skelton (2002) found at primary school level male teachers have been actively encouraged by the state to join a predominantly female workforce in order to improve education standards. Moreover men often enter the profession in primary schools at higher levels of the teaching hierarchy (Skelton, 2002). The term ‘feminisation’ is also linked to men losing part of their power and status, which reduces them to the same level as female workers, whose work is usually synonymous with lower pay, status and security compared to male workers (Francis, 2000).
The recent feminisation of professions raises the questions of why, and how, male-dominated professions become feminised when they are high status, usually require advanced qualifications, often follow an uninterrupted, linear career path, and are set within a context of patriarchal structures and working practices. Crompton and Sanderson (1990) have addressed this question extensively within the UK context, looking specifically at the professions of pharmacy and accountancy. Likewise Reskin and Roos (1990) have also looked at how male-dominated professions, such as pharmacy and finance, became feminised in the United States.

Reskin and Roos (1990) created the main theoretical model to explain the processes of feminisation of occupations and professions, and what happens once a previously male-dominated profession, or occupation, becomes feminised. They refer to this model as the “dual queuing process”, consisting of the “labour queue” and the “job queue”. The labour queue is described as the employer’s ranking of certain groups of workers in terms of their attractiveness, based on their expected high productivity but also their expected cost, whereas the job queue is the outcome of workers’ preferences and how they order prospective jobs in terms of attractiveness. Although this model may appear to be based on economic notions, Reskin and Roos (1990) note that there are also sociological, gendered aspects to these two queues. Using the “dual queuing process” model, Reskin and Roos (1990) highlight four main arguments to explain the feminisation of male-dominated professions, and occupations.

The first is that if professions and occupations are perceived to be becoming lower skilled, lower paid and less prestigious, men will start to place these jobs lower in the job queue and, consequently, fewer men are then in the labour queue for employers to choose from. As a result of this, women have the opportunity to enter the occupation or profession, and the feminisation process begins. This downgrading of jobs within the job queue may occur, according to Reskin and Roos (1990), because the salary is reduced, particularly relative to jobs that require a similar level of qualifications. Or, downgrading could be because the nature of a job changes, often due to technology change, which is leading to the deskilling of the job. Reskin and Roos (1990) argue the deskilling of jobs makes them less attractive to men because when
less skill is required, pay can be lowered and, as a consequence, the job’s status also decreases. For example, in the US, new technology was introduced into the baking industry, which meant that bread could be frozen until it arrived in store where it was simply placed in the oven to bake before selling. Therefore there was no longer a need to hire individuals, traditionally men, who had skills in making bread from scratch (Reskin and Roos, 1990). A decrease in employment security also makes jobs less attractive.

The second argument Reskin and Roos (1990) make for the process of feminisation is that there is a growth in a particular sector or profession that causes the labour demand to outweigh the supply of qualified men available to be employed. Therefore the labour queue is shortened so the employer is left with little choice but to employ the women available for that role. The third argument put forward by Reskin and Roos (1990) is that queues change because women constitute a greater share of the qualified labour pool for a specific role, so they rank more highly in the labour queue. This is becoming increasingly common in the UK, since more women than ever before are now obtaining university degrees (Purcell and Tzanakou, 2016). In 2016, 66,840 more women than men were studying degree courses in the UK – almost double the difference in 2007 (The Guardian, 2016). This has particularly been the case in medicine, as female medical students now outnumber male medical students (GMC, 2017a). Fourthly, Reskin and Roos (1990) use the real estate sector to argue that women are recruited into sectors where women’s share of the customer base is increasing. In the US, women were clustered in residential real estate sales roles, whereas men were clustered in commercial, non-residential real estate sales roles. A reason for the growth of women within real estate sector as a whole was due to the dramatic increase in demand for residential properties following the end of the Second World War. Therefore women were recruited into these emerging new roles within residential real estate, as they were associated with being women’s roles.

Reskin and Roos’ (1990) arguments are supported in Crompton and Sanderson’s (1990) work, and they also note the importance of social, political and economic changes that allow women to enter male-dominated occupations and professions in the UK context.
Crompton and Sanderson (1990) argue that the many facets of the state play a key role in encouraging or discouraging women from entering professions/occupations, and at what level. For example they find when the state encourages a male breadwinner model of employment where women are expected to claim the vast majority of childcare and domestic responsibilities, this view is then also reflected onto the employer. Therefore women tend to become employed in low paid and low status work as employers use stereotypes during the recruitment process regarding what types of jobs women should work in, and at the same time women find it difficult to work in male-dominated jobs that are perceived to require total commitment to work due to the state policies that promote women should be responsible for the family within the home.

While Reskin and Roos (1990) focus on the restructuring of occupations and professions in processes of desegregation and resegregation, other theories focus on how men in particular may try to prevent members of the opposite gender entering their occupations or having access to the higher levels of jobs within the occupation or profession. Consequently, individuals are also discouraged to enter occupations that are associated with the opposite gender. Research by Cockburn (1985) and Goldin, (2002) has found that male employees react more negatively towards female employees when entering a male dominated workforce. Goldin (2002) refers to this as “Pollution Theory of Discrimination” to explain that when women enter an occupation, male employees discriminate against female employees in order to ensure their occupation’s status is not “polluted” by the influx of women. Similarly, Cockburn (1985) found when the printing industry experienced feminisation that the male employees were hostile towards the female employees. However it is not always men that act negatively towards female employees. Other research has found that women also can discriminate and alienate their fellow female employees. Kaiser and Spalding (2015) found that women in higher positions of seniority did not want women in lower positions to follow in their footsteps and attempted to eliminate them from promotion and instead encouraged men to progress up the career ladder.
Bolton and Muzio (2008) used secondary analysis to explore whether feminisation is linked to a decline in professionalism, using the case studies of teaching, management and law. Overall they found that feminisation caused men to implement “defence mechanisms” that exclude women from reaching the higher echelons of the career hierarchy and the more prestigious areas of a profession across all three cases. They found in teaching that, despite the majority of the workforce being women, men dominate the senior hierarchical positions. Also, as pupils’ ages increase and consequently academic demands increase, the number of female teachers decrease once pupils reach secondary school, and even more so at A-Level. Similarly, they find in the legal profession that women are clustered in the specialisms that have lower status, lower pay and fewer opportunities for career progression – particularly family law. Legal firms benefit from an increased number of women as they add a “soft dimension to the professional image” (Bolton and Muzio, 2008, p.294), which may attract a previously untapped clientele. Even though the external barriers to women have been relaxed so women can enter the legal profession, internally there are still barriers created by organisations that work against women. Organisations have constructed these internal barriers by flattening organisational hierarchies so the influx of women can still be concentrated in the lower and middle ranks of the organisation whilst providing for and protecting the predominantly male senior employees. This also means that the vital ‘stepping-stones’ to reach more senior and higher paid positions are removed and thus female employees would have to remain in lower paid work for a longer period of time.

SECTION TWO: THEORY OF DEVALUATION

Reskin and Roos (1990) and Crompton and Sanderson (1990) describe how feminisation has occurred within specific occupations and profession, showing evidence that once professions and occupations become lower in status, salary and job security that men are discouraged from joining those professions. They also argue that gender segregation is not a static process and is “reproduced by cyclical practices, which are the outcome of past conventions regarding the ‘proper’ relations between
the sexes...relating to the domestic roles of women; formal and informal exclusionary practices; and fluctuations both in the demand for labour and the nature of female labour available” (Crompton and Sanderson, 1990, page 43). Therefore, even though women have been able to enter previously male-dominated, high paid, high status professions, women often work in the less prestigious areas and lower paid levels of those professions.

Other academics have built on these notions further, by exploring what happens to professions once they have become feminised, the most prevalent being “the theory of devaluation” (England, 1992; Kilbourne et al, 1994; Ackroyd and Muzio, 2007; Magnusson, 2009). The theory of devaluation predicts the outcomes of feminisation, suggesting that an occupation, or profession, becomes devalued and degraded in terms of salary, security and status as a result of an increased number of women in a profession (Mandel, 2013; Perales, 2010, Acker, 1990). Etzioni (1969) coined the term “semi-professions” to describe occupations that have become attractive to female employees, are subject to tight external control and involve an element of caring as a part of the job role. This implies that once a profession becomes feminised, it loses its status as a profession in its own right. Research conducted by Mandel (2013) in the United States supports the theory of devaluation and found that despite the apparent improvement in gender equality, indicated by women being able to enter male-dominated occupations more easily, these jobs have become lower paid. Mandel (2013) refers to this as “women moving up the down stair case”. Similarly, Perales (2010) found that once an occupation became feminised, wages would fall.

Magnusson (2009) also carried out research in Sweden to find out whether there is support for the theory of devaluation in terms of the relationship between gender composition and job prestige. Magnusson (2009) found some support for devaluation theory but the relationship between gender composition and job prestige is not linear since occupations with the most equal numbers of men and women have the most prestige. However, occupations that were male dominated still had higher levels of prestige compared to female dominated occupations. To build upon this preliminary research, Magnusson (2013) also quantitatively tested the relationship between
gender composition and salary. Even though evidence of devaluation was found, similarly to her earlier study, it was the occupations with the most equal male to female ratios that were the most highly paid. Garcia-Mainar et al (2018) researched the theory of devaluation in the Spanish context and did not find evidence to support the theory. Both Magnusson’s (2009) and Garcia-Mainar et al’s (2018) research shows that the country of study’s context may be influential in determining whether devaluation occurs once women enter a profession/occupation. For example, Sweden’s welfare policies include subsidised childcare that encourages women to return to work sooner after maternity leave. Therefore issues surrounding childcare, that may be a barrier to women’s career progression in countries without the same welfare benefits, may not have the same effect as in Sweden.

Research has shown that, once a profession becomes feminised, because men represent the minority they often achieve more positive career outcomes than women, referred to as the ‘glass escalator theory’ (Williams, 1992). Williams (1992) coined this theory as she found that men progress up the organisational hierarchy at a faster rate than women within a female-dominated profession, in stark contrast to the rate women progress within male-dominated professions. Therefore male employees in a feminised profession are often referred to as “token men” (Pullen and Simpson, 2009). Contrary to this, Kaiser and Spalding (2015) provide evidence that women in higher positions in male-dominated professions (often “token women”) undermine the advancement of women below that follow them and instead encourage men into the more senior roles. This has also been the case in nursing where women (consciously or subconsciously) “nurtured” the careers of male nurses, which meant they progressed up the career ladder more quickly than female nurses (Evans, 1997). Evans (1997) argues that this happened because the institutional setting was patriarchal, especially since the nurses were dealing with male doctors senior to them for the majority of the time. Therefore, female nurses were the “oppressed group”, allowing for their male nurse colleagues to progress their careers more easily. Much research has been conducted within the feminised profession of nursing, particularly in terms of women’s career advancement. Winson (1992) found that promotion was only possible for female nurses who had not taken a career break and who had continued to work full
time. Despite a large amount of research supporting the view that once occupations become feminised, they become devalued, other research has shown that feminisation can have positive outcomes in terms of flexible working, more upward career progression and higher salaries for women, and an improved client base for organisations (Vehvilainen et al, 2010; Levinson and Lurie, 2004; Brundser, 1996; Sommerlad, 2002; Standing, 1989). However, research highlighting the benefits to women after feminisation is outweighed by the amount of research supporting the theory of devaluation. Moreover, the benefits for women may be mainly in relation to their previous opportunities so that women may still benefit from moving on to a downward-moving escalator provided it starts at a high level.

It can be seen from these two sections of the literature review that working time is a key aspect of the phenomena of gender segregation and the theory of devaluation, as there is evidence that women are excluded from more prestigious areas and higher levels of occupations and professions based on the premise that they are unable to work longer than their standard working hours due to holding the majority of childcare responsibilities (Bolton and Muzio, 2008). In turn, ‘women’s work’ becomes devalued, as it is perceived that the woman’s role is within the home, and not as the breadwinner for the household. The next section aims to explore the working time trends in the UK, and working time in professions, to establish the potential issues women working within professions may experience, and why.

**SECTION THREE: WORKING TIME**

The increase of women entering the labour market, particularly professional roles, has led to women’s working time preferences becoming increasingly more varied (Fagan, 2001) and for issues around work life balance to come to the fore (Fleetwood, 2007; Özbilgin et al, 2011) since women continue to have predominant responsibility for childcare and domestic tasks in the home (Lyonette and Crompton, 2015). Despite the evidence that men in dual earner households are taking more responsibility for unpaid work (Sayer, 2005) and that fathers are showing an increased interest in childcare
friendly working practices (Gatrell et al, 2014), these increases in male participation in childcare and domestic tasks in the home do not appear to be matching the rate of female participation within the labour market (Kan et al 2011; Anxo et al, 2013). On the one hand it is argued that women use their agency and choose to work ‘flexible’ hours to achieve a work-life-balance (WLB) (Kahne, 1992; Hakim, 1996; 2006), whereas others argue that employers use flexible working hours as a guise to manipulate working time arrangements to gain a cheaper source of labour and increase productivity, depending on organisational demands (Rubery et al, 2005a; Fleetwood, 2007).

Alongside this, working time trends in the UK are generally shifting towards a culture of long hours working (Kodz et al, 2003), increased unsocial hours work and consequently a “results-based model” of working time that suits the needs of the employer (Rubery et al, 2005a). The results-based model is based on the premise that working time is calculated on the time taken to complete a job. However, if this time is over the standard, scheduled working hours often no additional pay premium is received for those additional hours to complete the work (Rubery et al, 2005a). In a similar vein, there is also the changing nature of industrial relations in the UK to suit the needs of the employer, since there is a shift away from the ‘traditional industrial relations model’ (Rubery et al, 2005b) whereby trade unions negotiated working time and wages for unsocial working hours, towards an ‘employer-led system’ that promotes part-time work and unsocial hours for little or no extra pay. Therefore these changes ultimately have negative impacts on female workers, since they are more likely to work part-time and unsocial hours (Rubery et al, 2005a).

WORK LIFE BALANCE AND FLEXIBLE WORKING

The literature concerning working time frequently focuses on work-life-balance (Rubery et al, 2015), which often concerns women, especially those with dependent children (Fleetwood, 2007; Ransome, 2007). Work-life-balance discourse is not a recent phenomenon (Lewis et al, 2007) and the terminology has been contested and changed throughout its time (Prowse and Prowse, 2015). Work-life-balance can be defined as:
“People having a measure of control over when, where and how they work. It is achieved when an individual’s right to a fulfilled life inside and outside paid work is accepted and respected as the norm” (Fleetwood, 2007, page 351).

Therefore, the ‘work’ is classified as the paid working hours and ‘life’ is defined as everything outside this. However there is much debate regarding the ‘life’ aspect of ‘work-life-balance’, and that the definition of ‘life’ should not incorporate both unpaid work (such as childcare and cleaning) and leisure time under the same term (Ransome, 2007; Gatrell, 2007). Consequently Ransome (2007) added a third dimension ‘recreational labour’, which accounts for leisure activities, such as going out to a nightclub with friends, and even aspects of childcare, such as playing games with the children rather than tidying up after them.

In earlier WLB literature, the notion was referred to as ‘work-family conflict’ and ‘family-friendly’ working, with an implicit focus on female workers with children, based in the setting of a dual-earner household (Ransome, 2007). Therefore a shift to the gender-neutral term ‘work-life-balance’ was deemed more appropriate to ensure both men and women were engaged in the discourse since there is evidence that men are also increasingly seeking a WLB (Tipping et al, 2012). Moreover, workers of both genders seek a better work life balance for reasons outside of childcare, such as for leisure and friendships (Pedersen and Lewis, 2012) and to care for elderly relatives (Cabrera, 2007). Although the terminology has changed, the underlying issues remain the same and primarily apply to women who are still the prime carers for their children and family (Lyonette and Crompton, 2015). Due to women holding the majority of the childcare and domestic responsibilities within the household, women are more likely to work part-time, unsocial hours, unpaid overtime and require work-life-balance initiatives more than men (Crompton and Lyonette, 2005). Therefore, it could be argued that work-life-balance largely remains an inherently “woman’s issue” (Fleetwood, 2007; Lewis et al, 2007).
There are well-documented benefits and business cases, although contested, linked to WLB practices for both the employer and the employee. Some argue that WLB policies increase productivity, improve recruitment, reduce rates of absenteeism and create a more equitable workforce (Beauregard and Henry, 2009). The TUC (2001) has also shown its support for WLB policies saying that organisations that implement them are forward-looking and profitable. However it is also argued these business cases hide a multitude of problems (Fleetwood, 2007). Fleetwood (2007) argues that employees and employers strive after differing flexible-working practices in order to achieve a work-life-balance. Those that are sought by the employee are usually “flexible start and finish times, term-time working, voluntary part-time, job-share, compressed working weeks...shift swapping, self-rostering, time off in lieu, sabbaticals and career breaks” (Fleetwood, 2007, page 389), whereas employers strive for different flexible working practices, often referred to as “employee unfriendly”. Examples of employee unfriendly working practices are “involuntary temporary working and involuntary part-time working (with loss of pay), zero hours contracts, unsocial hours working such as twilight shifts, 24 – 7 shift rotations, Saturday and Sunday working, overtime (especially enforced and/or unpaid), annualized hours, stand-by and call-out arrangements, seasonal work and job-and-finish” (Fleetwood, 2007, page 389).

Even though these ‘un-friendly’ working arrangements may fit the needs of some employees, it is argued that the majority of employees do not see these as desirable (Fleetwood, 2007). Fleetwood (2007) supports this claim by arguing employees often “fight hard” to obtain benefits associated with these employer-friendly working arrangements, such as unsocial hours payments. It could be argued that mothers may opt to work unsocial working hours, such as nighttime shifts, in order for partners or family to look after children during the evening (Fagan, 2001). However, whether this is a genuine free ‘choice’ or an example of an imposed ‘employee-unfriendly’ working arrangement is debatable. Fleetwood (2007) believes that this arrangement should not be referred to as ‘friendly’ since the mother loses out on quality time with her partner in the evenings and the children’s bedtime routine (such as reading a bedtime story).
As seen in Fleetwood’s (2007) definition of work-life-balance earlier, within much of the work-life-balance literature there are strong implications that work-life-balance is a matter of the employee’s personal choice and “personal control” (Lewis et al, 2007). However it could be argued that the employee has little control of their work life balance in situations such as zero-hours contracts and unpaid overtime. Therefore it is not entirely clear who is making these ‘choices’, controlling WLB policies and promoting their use. Fleetwood (2007) questions whether it is employers, employees, trade unions, women with children, or the government who promote WLB issues. This remains an ambiguous question and one that remains unaddressed.

The WLB literature has faced criticism that it disregards the institutional, structural and gendered constraints (Fleetwood, 2007; Lewis et al, 2007; Özbilgin et al, 2011). Another criticism of WLB practices is that they conceal organisational and societal controls and serve the interests of the employer (Lewis et al, 2007; Fagan, 2001; Fleetwood, 2007). Fleetwood (2007) refers to this concealment by calling WLB practices a “Trojan horse” that has entered the workplace causing employee-unfriendly working practices to be legitimised. Also, it is argued that WLB is based on the assumptions that females are the primary carers which reinforces and reproduces gender inequalities since it is still usually women who opt for part-time work, which is renowned for lower pay, lower job security, lower status, increased work-intensification and lack of career advancement (Warren and Lyonette, 2018, 2015; Thornley, 2007). Therefore, women’s ‘choices’ will be based upon the male-breadwinner model, unless societal views and norms are changed (Barlow et al, 2002).

**Part time work**

Women are much more likely to work part-time compared to men in the UK (ONS, 2018a), and part-time work is often situated as central in achieving WLB (Tomlinson, 2007). There are conflicting debates concerning the advantages and disadvantages to part-time work. Some argue that part-time work offers the best of both worlds, whereby employees can earn a wage whilst also balancing their family life (Duffy et al, 1989). However, as mentioned previously, part-time working hours are often in the interest of the employer to reduce costs and increase productivity - causing detriment
to employees (Fleetwood, 2007). Therefore female employees are more likely to be at a disadvantage since they represent the majority of part-time workers. These disadvantages come in the forms of lower pay, limited access to training provisions, fewer opportunities for career progression and lower job satisfaction (TUC, 2014; Arulampalam and Booth, 1997; Higgins et al, 2000; Crompton et al, 2010). The TUC (2014) found that the majority of women working part-time earn less than the living wage. The worst area in the UK is in West Lancashire where 73.9% of women working part-time earn less than the living wage. Also, even though women who choose to work part-time may appear to have more time at their disposal, this means they are responsible for the majority of unpaid work in the home. This situation is summed up in a quote from a participant in Higgins et al (2000, page 27) who said: “since I work fewer hours, I figure I can do everything...you are never not working”.

When women return to work part-time after having a baby they also face discrimination in terms of future career progression (Higgins et al, 2000; Gatrell, 2007). Gatrell (2007) argues there is aversion towards the “maternal body” that plays a part in career mothers who work a fraction of full-time hours being seen as on the ‘mommy track’ with their chances of promotion lessened. Derogatory terms, such as “mommy-brain” (Ellison, 2005), imply mothers are mentally less capable than they were prior to having children, which also adds to the stigma of being a mother in the workplace. To address these disadvantages, Higgins et al (2000) suggest that organisations need to offer part-time work that is rewarding and desirable, such as HR initiatives to provide training to all employees about the pressures of work-family conflict.

WORKING TIME AND PROFESSIONS

Key characteristics of working time in professions

Professionals tend to define working time on the premise of how long it takes to complete a task/job (Zerubavel, 1981), in line with the results-based model of working time (Rubery et al, 2005) discussed earlier. As a consequence, working hours in

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2 The National Living Wage, introduced in April 2016, is a voluntary hourly rate calculated according to the basic cost of living in the UK. The current UK living wage, outside of London, is £8.75 an hour (2017/18). The current London living wage is £10.20 an hour (2017/18).
professions are inherently long (Kodz et al, 2003). Figure 1, derived from the ONS (2017) Annual Survey of Hours and Earnings (ASHE), shows the average paid full-time weekly working hours of a range of professions, including teaching and education, law, chartered accountancy, IT, architecture, nursing and midwifery, veterinary medicine, and policing in the UK.\(^3\)

**Figure 1: Average total number of paid (full-time) weekly working hours of professions, in the UK**

![Bar chart showing average weekly working hours for various professions](chart.png)

Source: derived from (ONS, 2017) Table 14.9a Annual Survey of Hours and Earnings: 2017 data

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\(^3\) Full descriptors and ASHE codes of professions included within this analysis of Table 14.9 of the ASHE (ONS, 2017) are as follows: Teaching and educational professionals (231); Legal professionals (241); Chartered and certified accountants (2421); IT and telecommunications professionals (213); Architects (2431); Nursing and midwifery professionals (223); Veterinarians (2216); Police officers (sergeant and below) (3312).

\(^4\) Medical practitioners (2211) have been excluded from this analysis as their paid full-time working hours have been calculated on their basic contracted hours of 40 hours per week, and does not include paid on-call working hours, which is usually 8 hours per week.
Figure 1 shows that the average paid, full-time working hours in these professions range from 32.5 hours a week in teaching and education, to 40.2 hours per week for police officers. However, it should be noted that the national ONS data available does not include unpaid overtime hours, which the TUC (2017) finds adds a significant number of working hours to professionals’ working weeks. For example, legal professionals work an additional 9.1 unpaid hours per week, and teaching and educational professionals work an additional 12.1 unpaid hours a week (TUC, 2017). In addition, a recent report produced by the Department of Education (2016) confirms that teachers work over 50 hours per week. The most recent NHS Staff Survey (2018) shows, on average, 79.2% of doctors and dental employees in training also work additional unpaid hours. Therefore, additional unpaid working hours, which are commonplace in professions, means most professionals work over 40 hours per week and thus significantly higher the average UK full-time working hours of 36.9 hours per week (ONS, 2018b).

Working long hours in professions is often linked to notions of patriarchy, and increased professionalism and commitment to the profession, that is ingrained within many professional and organisational cultures, as seen in accountancy (Lewis, 2007); law (Bolton and Muzio, 2007), midwifery (Prowse and Prowse, 2015), architecture (Sang et al, 2014) and the veterinary profession (Clarke and Knights, 2018). In many private sector professions, such as law and accountancy, time is seen as a commodity, where clients are billed according to the time taken to complete a job. Therefore, to remain competitive in the market and avoid downward pressures on costs from senior management regarding time taken to complete work, employees record their working hours as lower than the actual number of hours worked, causing any additional hours taken to complete the work to be unpaid (Lewis, 2007). Sang et al (2014) find in a male-dominated profession, such as architecture, long working hours are normalised through the societal norms that a man’s role is to be in the workplace rather than within the home (referred to as ‘hegemonic masculinity’). Hegemonic masculinity further “perpetuates gendered norms that marginalise women” (Sang et al, 2014, p.258) in the work environment, in terms of their career progression and pay opportunities. The intensification of working time is also common within many other
professions, particularly law, due to the pressures of increasing client demands caused by a 24/7 service culture becoming the norm (Sommerlad, 2016). As a result, women with children working in professions with long hours cultures often face tensions between the socially constructed ideology of being the ‘ideal mother’ whilst also being the ‘ideal worker’ (Lewis, 1991).

Long scheduled paid working hours, alongside unpaid additional hours, are associated with the male breadwinner model of working time, where it is expected that the man within the household is responsible for the majority of the household income (Smithson et al, 2004). Therefore, now many traditionally male-dominated professions are feminising, the need for flexible working time arrangements has increased (Fleetwood, 2007; Özbilgin et al, 2011). There also appears to be a generational shift in attitudes towards long working hours, with the younger generation being more motivated by achieving a good work life balance (Wallace, 2006) and associating increased efficiency, and capability, with working fewer hours (Lewis, 2007). In addition, it is not solely women with children who seek flexible working time arrangements as solo-living professionals are an emerging, under-researched demographic who are increasingly having WLB concerns (Wilkinson et al, 2017).

Implementing flexible working practices, such as part-time work and flexi-time, is challenging in professions because of rigid workplace and professional cultures, and structures (mentioned above) that promote gendered working time patterns of the male breadwinner model (Rapoport et al, 2002). Moreover, employees who challenge gendered organisational practices, such as long working hours, rarely have the sufficient authority to do so (Sirianni and Negrey 2000).

Despite working long hours, many professionals are seen to have working time flexibility and autonomy (Lewis, 2007). Advancements in technology have assisted with this increased flexibility and enabled ease in childcare arrangements in some instances as work can be completed at home (Baruch, 2000). However increased ‘work contact’ within the home can also cause the boundaries between the work and home environment to become blurred, leading to increased work-family conflict and stress (Bowen et al, 2018; Kay et al, 2013; Lewis and Cooper, 1999). Moreover, employees
who frequently work from home are more likely to work over 48 hours per week (Tipping et al, 2012).

Due to the long hours culture in professions causing an open-ended nature of commitment, professional women often have no option but to work part-time hours to balance home and family life (Grimshaw and Rubery, 2002). To illustrate part-time working hours in professions, Figure 2 shows the average part-time paid working hours for teaching and education professionals, legal professionals, chartered accountants, IT professionals, architects, nurses and midwives, veterinarians and police officers in the UK (ONS, 2017)\(^5\). Policing, a profession that remains dominated by men (Home Office, 2017), has the highest average number of part-time paid working hours, compared to the long-established feminised profession of teaching and education who work the lowest number of part-time paid working hours. However it should be noted that these figures do not include unpaid additional working hours since, similarly to professionals working full-time hours, research shows part-time professionals also work above their paid, scheduled working hours for no additional remuneration (Corwin et al, 2001). However part-time women professionals struggle to make the time for non-paid additional work because of their childcare and domestic responsibilities (Wass and McNabb, 2006). For example, in the legal profession, Wass and McNabb (2006) find that female solicitors are unable to commit to non-billable working hours, which subsequently leads to a lack of career progression opportunities.

\(^5\) See footnote 3 for full descriptors and ASHE codes for professions included within this analysis.
Although working part-time can assist in balancing work life and family life, the restriction to career progression caused by working part-time in professions is commonplace, particularly for women who remain to hold the majority of childcare responsibilities (Walsh, 2012; Durbin and Tomlinson, 2010; Smithson et al, 2004; Crompton et al, 2003). The most recent 2011 Workplace Employment Relations Study (WERS) shows that the majority of professionals surveyed strongly agreed, or agreed, with the statement: “people in this workplace who want to progress usually have to put in long hours” (Van Wanrooy et al, 2013). As indicated earlier by Sang et al (2014), a workplace culture of long working hours is a form of ‘hegemonic masculinity’, which has knock on consequences for women as they are less likely to be able to work long hours due to childcare and domestic duties within the home.
Smithson et al (2004) looked at part-time chartered accountants, and found women were more likely to work part-time due to childcare responsibilities, whereas male chartered accountants were more likely to work part-time towards the end of their careers once they had progressed further, in terms of both their seniority and salary. Therefore female chartered accountants were much more likely to suffer financially throughout their careers compared to their male counterparts, meaning “time becomes the most differentiating feature which makes men more likely to achieve promotion” (Rutherford, 2001, page 259). Similarly, The Law Society survey titled Women in the Law (2018b), found 49% of those surveyed felt the unacceptable work life balance in the legal profession prevented them from reaching senior positions. The exclusion from “male networks” has also been found to restrict female part-time professionals from achieving promotions in accountancy (Crompton and Lyonette, 2010) and law (Bolton and Muzio, 2008). In addition to part-time work limiting progression opportunities, Conley (2002) finds that part-time work in the UK teaching profession in many instances leads to job insecurity since part-time contracts are often offered on a fixed-term, rather than permanent, basis.

However, Higgins et al (2000) argue that not all part-time jobs are ‘bad’. Higgins et al (2000, page 18) suggest that women in professional careers often switch to part-time work for “personal and professional fulfilment” when balancing work and family life, whereas those in non-professional jobs are more likely to be seeking increased income. The experiences of women in these jobs differ quite considerably. Women who work part-time in ‘non-career’ jobs often report that they are satisfied with their work and working part-time allows them to socialise (Higgins et al, 2000). However, women in professional, ‘career jobs’ often have to individually negotiate to work part-time rather than the option being readily available and encouraged (Higgins et al, 2000). In addition part-time female professionals were less satisfied, more stigmatised and experienced more work-overload than ‘non-career’ part-time women. It should be noted that since Higgins et al’s (2000) research, the UK has introduced the Flexible Working Regulations 2014. The legislation allows all employees, regardless of whether they are a parent, or carer, the right to request flexible working hours. Therefore perhaps part-time working options are now more readily available and encouraged, or
perhaps this legislation provides the rhetoric of flexible working, yet the decision-making still lies with the employer as the employer also has the right to refuse flexible working requests.

As well as working part-time, another strategy female professionals use to avoid the long working hours culture embedded within professions and organisation is transitioning to become self-employed so they have the opportunity to work from home and determine their own working hours (Craig et al, 2012; Crompton and Lyonette, 2010). A similar situation is happening in the UK teaching profession where many teachers, mainly women, are choosing to become self-employed or agency supply teachers due to unreasonable workloads (NEU, 2018).

The impact of flexible working practices in professions on the colleagues who remain working full-time should also be noted here, which is particularly prevalent in caring, health professions bound to the UK public sector, such as nursing and midwifery (Prowse and Prowse, 2015). Prowse and Prowse (2015) find that full-time midwives in the NHS feel disadvantaged by flexible working as they pick up additional work. This is most likely due to there being too high a demand from patients for the limited number of midwives available, as the Royal College of Midwives (RCM) report NHS England has a shortage of 3500 midwives (RCM, 2018). Prowse and Prowse (2015) also highlight that balancing the different working time needs of a female-dominated workforce is problematic within a 24/7 profession as “the need for flexibility is undermined by the necessity for predictability, as midwives need to know when they will work and this results in inflexibility” (Prowse and Prowse, 2015, page 758).

This section, and the previous two sections, of this literature review highlight that the roles of the state can play a key role in shaping occupational gender segregation (Crompton and Sanderson, 1990), the devaluation of occupations/professions, and men and women’s working time. The state is the employer for the vast majority of medical professionals in the UK. Therefore the roles of the state take on particular importance in determining the implications of, and responses to, the feminisation of the profession, which are discussed in the following section.
SECTION FOUR: THE ROLES OF THE STATE

INTRODUCTION
It is necessary to explore the role of the state; and the interrelation of actors, institutions and regimes at play when analysing the position of women working in the public sector (Rubery, 2014), such as the female doctors working in England whom are the focus of this research. The role of the state, particularly in regard to the NHS, is complex and multi-faceted. Therefore, this section begins with a comprehensive discussion on how ‘the state’ is defined for the purposes of this thesis. There is a primary focus on the state’s role as the employer and within public sector employee relations, due to the majority of doctors (excluding GP Partners) whose employment is shaped by the state, through the NHS. Next, there is an overview of the historical evolution of the state, and how political parties’ ideologies reform and shape, not only public sector employment, but also in relation to the economic, equality, employment legislation, and public service provision implications. The UK political and economic context during the time of writing this thesis was shaped by a long-term Conservative-led parliament, post economic recession and, as a consequence, a prolonged period of ‘austerity measures’. This political and economic context provides the backdrop to the discussions throughout this thesis. Finally, since this thesis focuses on the feminisation of the medical profession, the issue of how women experience employment in the public sector, and during a period of austerity, is also explored.

DEFINITION OF ‘THE STATE’
The ‘state’ is generally defined as the elected government in power, and the government-led agencies that enact its policies (Dundon and Rollinson, 2011). For the purposes of this thesis, the role of the state is defined mostly by how its roles and actions (re)shape employment relations, particularly those within healthcare. Numerous academics have explored the roles of the state within employment relations (Fredman and Morris, 1989; Winchester and Bach, 1999; Corby and White, 1999; Greener, 2003; Hyman, 2008; 2012). Public sector employment holds a number of key features that makes it different from the private sector. For example, despite
attempts by the state to lessen trade union power (Bach, 2016), the UK public sector has a higher level of trade union membership compared to the private sector (ONS, 2016). Moreover women account for the majority of the workforce (Cribb et al, 2014); and many professions are largely bound to the public sector, such as teaching, nursing, dentistry and medicine – all of which are long-established, and some recently feminised.

However a significant feature is that the state is effectively the employer, which has multiple implications for the employment relationship. Workers, employers, trade unions/collective bodies (if applicable) and the state typically shape the employment relationship (Edwards, 2003). Therefore, in the public sector, the state effectively “occupies two seats at the table” (Hyman, 2008, page 265). Fredman and Morris (1989) identify five key features of the state in its role as the employer. First, the state ultimately has the power to implement its own legislation. In this regard, the state is effectively an “elected dictatorship” (Wincester and Bach, 1999, p.20). Secondly, Fredman and Morris (1989) argue the state as a public sector employer does not strictly rely on the productivity of its workforce for its income – instead this comes through taxes. Thirdly, there is a ‘public sector ethos’, where the state “claims to represent the national interest in order to justify its actions, which gives moral authority to its employment decisions” (Fredman and Morris, 1989, p. 4). Fourthly, the public sector arguably has more ‘constitutional constraints’ compared to the private sector when decision-making. This can link to the earlier feature of a ‘public sector ethos’, where decisions should be seen as fair and moral, so are therefore under more scrutiny from the public, i.e. the electorate. Finally, public sector employers’ authority is built on power relationships, represented through hierarchies, rather than capital ownership as seen in the private sector.

The state in its role as the employer also has a history of being perceived as the “model employer” (Morgan and Allington, 2002), facilitating women into the labour market (Rubery, 2013) and, as a consequence, providing a perceived commitment to family friendliness (Yeandle et al, 2002). Consequently the state’s image as the ‘model employer’ has been seen to set the precedent of how private sector employers should
behave. However, whether the state truly acts as the ‘model employer’ is debateable (Hyman, 2008; Coffey and Thornley, 2009). There are also questions as to whether the state’s actions are truly in concordance to the Public Sector Duty, particularly during times of austerity measures (Conley and Page, 2018). These debates are discussed later in this section.

Whilst Fredman and Morris (1989) look at the role of the state as the employer, Hyman (2008) sets out a broader framework identifying the multiple roles of the state. He argues, as well as being an “employer in its own right” of public sector jobs, the state has six other roles that shape national employee relations (Hyman, 2008, p. 264). Put briefly, these are:

1. procedural regulator;
2. legislator of employment rights;
3. economic manager, through shaping the labour market and;
4. shaping the employability of the labour market;
5. shaping the welfare state; and
6. promoting social citizenship guidelines

Hyman’s (2008) features of the state are considered and developed in further detail in this next section. To discuss these features in detail, it is necessary to outline the historical political evolution of the roles of the state mentioned above, and how these roles have shaped employee relations over the recent decades.

**EVOLUTION OF THE STATE’S ROLES WITHIN PUBLIC SECTOR EMPLOYMENT**

The actions of the state, within its various roles mentioned above, tend to reflect the political philosophies and priorities of the government in power (Dundon and Rollinson, 2011). Much of the academic literature argues the public sector was perceived as the “model employer” during the 1970s when the Labour party were in power by providing secure jobs, strongly recognising trade unions to facilitate collective bargaining and embracing equal opportunities by employing large numbers of women (Morgan and Allington, 2002). However, during this time there was a UK
recession, rising unemployment levels and relatively high inflation. Since many services, such as rail, utilities and telecommunications were part of the public sector, there was widespread industrial action relating to pay, reaching its peak in the late 1970s. Therefore, whether the state as an employer was truly “model” during this time is contested (Coffey and Thornley, 2014). Following the Labour governments from 1974-79, May 1979 saw the election of Margaret Thatcher, leader of the Conservative party. During the Thatcher years, the UK public sector changed dramatically due to the neo-liberal philosophy of the Conservative party embracing entrepreneurship, free markets, privatisation, consumerism and reduced trade union influence (Simonet, 2015; Coffey and Thornley, 2009). Strategies promoting this restructuring of work in the public sector are referred to as ‘New Public Management’ (NPM). Corby and White (1999, p.19) argue that NPM is a combination of both managerialism and neo-Taylorism that “emphasises the control of government spending, decentralising management, setting targets, and measuring and rewarding performance”. As a result of NPM, during the 1980s and early 1990s, many public sector jobs were cut and those remaining were perceived as less secure (Simonet, 2015). Moreover many public sector organisations, such as British Gas and British Airways, were privatised and legislation was introduced that made collective bargaining and industrial action more difficult.

New Public Management has been associated with the downgrading of public sector jobs, as pay is reduced to meet stricter ‘business-like’ budgets (Conley et al, 2011; Bottery, 1996; Hood, 1991). In addition, the privatisation of parts of the public sector has led to work intensification due to increased internal market competition to meet strict targets (Simonet, 2015; Green, 2001). New Public Management is also argued to contradict the notions of the ‘public service ethos’ as it “emphasises entrepreneurial characteristics such as business need, cost minimisation, innovation and flexibility for managers to deploy their resources as they think fit” (Corby and White, 1999, p.19). Whereas the public sector ethos is built on notions of standardisation, fairness, risk aversion and morality (Fotaki, 2010; Fredman and Morris, 1989; Corby and White, 1999). New Public Management also promotes a ‘consumer rhetoric’ (Simonet, 2015; Greener, 2003; Bolton, 2002) whereby public sector users are defined as customers
and consumers, similarly to if a private sector organisation. Greener (2003) analyses how the consumer rhetoric of the state’s healthcare policies have evolved since the formation of the NHS in 1948. Although patients have had the option to choose their own GP since the formation of the NHS, Greener (2003) finds that there has been a slow move towards a consumer-based model, based on the continuation of providing patients with more choice and decentralising decision-making so more accountability lies with medical professionals, and Finance Managers (Bolton, 2002). For example, the Conservative government introduced the policy ‘Working for Patients’ in 1989, which reinforced that patients had the choice to opt for private healthcare, and by doing so they would benefit the local community by reducing pressures on public resources (Greener, 2003).

The Conservative-led government remained in power until 1997, when the Labour Party was elected once again – branded as ‘New Labour’, led by Prime Minister Tony Blair. However, similarities were drawn between ‘New Labour’s’ ideologies and the neoliberal views of the Conservative party, in that they both encouraged aspects of NPM. Ideas of competitiveness and partnerships between the public and private sector was continued, as public sector workers were given increased performance targets, there was the continued outsourcing of jobs and the introduction of increased bureaucracy (Bach, 2002). As a result, work intensification in the public sector continued (Bach, 2002). New Labour also encouraged the idea of social citizenship guidelines into the public sector (Dundon and Rollinson, 2011). For example, in the teaching profession policies were put in place that “required teachers to engage directly with parents and other agencies to ensure that education became the cornerstone of social policy” (Conley and Jenkins, 2011, page 489). The differential impact this had on men and women is discussed later in this section.

However, at the same time, New Labour invested more money into public services – particularly health and education due to a period of economic growth in the early 2000s. Promoting fairness for workers, particularly in regards to improving work life balance, was also a central feature of the New Labour government rhetoric. Coinciding with this, in 1999, the European Union implemented ‘gender mainstreaming’ as part of
the European employment strategy. This meant a requirement for “gender equality issues to be built into all policy programmes and has the potential double benefit of ensuring that gender effects are taken into account in the initial design and of providing a basis for new and transformatory approaches to policy-making” (Rubery, 2002, page 501). Workplace equality was also given more prominence in public service policy, through the development of three key equality duties during the 2000s. Firstly, following the Stephen Lawrence case⁶, the Race Equality Duty (2001) was established. In 2006, the Disability Equality Duty was implemented, shortly followed by the Gender Equality Duty in 2007. Equality duties placed the onus on the public sector to act fairly towards, not only public sector employees, but also users of public services prior to acts of discrimination taking place (Conley and Page, 2018). Through the equality duties the state was encouraged to conduct equality impact assessments. When enacted properly, they highlight potential discriminatory practices of public authorities (Conley, 2012). In addition, the three equality duties provided public sector workers and users the power “to request a judicial review of decisions made by public authorities that have not given due regard to equality” (Conley, 2012, page 349).

Then in 2008 came the global financial crisis, which led to the recession and consequent period of austerity after the Conservative/Liberal Democrat coalition government was elected in 2010, led by David Cameron. During this period of austerity the coalition government implemented the Equality Act (2010), which had been passed in the last months of the Labour government. Section 149 of the Equality Act (2010) contains the Public Sector Equality Duty (PSED), whereby the state in its role as an employer and public sector provider should have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Therefore the state’s ‘model’ image encompasses fairness and equity, not only to its employees, but also to users of public services. However it is argued that during times of austerity, the state is “thwarts legal enforcement of equality when its economic authority and the interests of capital are threatened” (Conley, 2012, page 349; Conley and Page, 2018). This was evident during the leadership of the coalition government. David Cameron announced in his speech to the Confederation of British Industry, on 19th November 2012, that there would no longer be a legal requirement for the state to undergo equality impact assessments when creating policies. Cameron referred to equality impact assessments as “bureaucratic nonsense” that wasted time and public taxpayer’s money. Therefore items within Section 149, which incorporate the gender, disability and race equality duties mentioned earlier, were limited in their effectiveness due to a change in approach from reflexive law to reactive law, whereby the state reacts to issues surrounding equality after policies have been proposed/implemented (Conley, 2012). A recent report conducted by the Equality and Human Rights Commission (2018) assesses the effectiveness of the PSED. They found that compliance towards the PSED was not guaranteed. Moreover, attempts to promote equality were often based on ‘business case’ reasons, rather than to truly achieve social justice, fairness and equality. For example in the NHS, complying with the PSED was seen as beneficial when bidding for contracts, as it is a specific requirement to demonstrate when making bid applications.

Austerity did not only consist of changes to equality legislation, job and pay cuts to public sector jobs, but also continued privatisation of many public sector services, such as parts of the NHS and Royal Mail, due to a “neo-liberal desire to reduce the state sector” (Lewis et al, 2017, page 588). By reducing the state sector, the state effectively diffuses financial responsibility onto private sector and voluntary sector organisations.
(Bach, 2016). Effectively, it could be argued that ‘austerity measures’ are used as a means to ‘refashion’ New Public Management (Bach, 2016). Since the election of a Conservative government, trade unions’ collective bargaining power has also diminished further as the state has enacted policies to limit union’s negotiations and actions (Bach, 2016). For example, the Trade Union Act 2016 that puts additional burden on public sector workers as a result of increased requirements for ballot voting and the notice period workers are required to give to their employers to take industrial action.

The turbulent history of the state as the employer over the last 50 years has led to the argument that there is a tension between the state as the model/good employer that “suggests a deficit in private sector employment practice which should warn against liberalisation” (Coffey and Thornley, 2009, page 81) at the same time as introducing private sector ideologies into the public sector (Hyman, 2008; Coffey and Thornley, 2009). Hyman (2008), and Coffey and Thornley (2009) add to this argument to say this tension is heightened during a period of economic austerity, as the state has an overarching capitalist logic. Therefore austerity measures are put in place that cut public sector budgets and spending, which leads to pay reductions, pay freezes and job losses. Consequently the psychological contract is broken down between public sector workers and the state, damaging the state’s image of the ‘good employer’ (Bach, 2016). Moreover there are arguments that the state trades off its equality duty for capitalist gain during times of austerity (Conley, 2012; Carter, 2000; Conley and Page, 2018). Therefore the political economy clearly shapes public sector employment relations. This is particularly the case with regards to the operation of the NHS, and the subsequent implications on employment terms and conditions, which are discussed in further detail within Chapter Three.

**WOMEN AND PUBLIC SECTOR EMPLOYMENT**

Within the public sector generally lies a predominantly female workforce (Cribb et al, 2014) whose work is polarised. On the one hand there are many women, particularly Black, Asian and minority ethnic (BAME) women, concentrated in low paid, low status work (Thornley, 2007; Healey et al, 2011) but women also represent the majority of
those working in highly-qualified professions in the public sector, such as nursing and teaching, and now medicine (NHS Digital, 2018b; Department of Education, 2017; GMC, 2017a). As highlighted previously, women are more likely to seek flexible working practices and requests for flexibility are more often granted in the public sector (Gregory and Milner, 2008). However, McBride (2003) argues this creates tensions for who is granted flexible work, as there are pressures on the state to implement cost-effective working time practices whilst suiting the needs of a predominantly female workforce.

New Public Management is argued to have had a significant negative impact on female public sector workers (Conley et al, 2011). Conley and Jenkins (2011) explored teachers’ employment experiences within the UK public sector and they find the pressure to meet targets has led to unreasonable workloads that are incompatible with having a family-life. For example, marking and lesson planning is often carried out in the home due to no time to complete the work during their scheduled working day. Therefore many women with childcare responsibilities struggle to work full-time hours so resort to part-time hours or leave the profession until their childcare responsibilities become easier to manage once children reach school age (Conley and Jenkins, 2011).

In addition, as mentioned earlier, part time workers usually have limited access to training that helps progress their careers (Arulampalam and Booth, 1997). Despite the state striving to be seen as the model employer compared to the private sector (Morgan and Allington, 2002), part-time employees also face barriers to progression in the public sector, as lowering costs and meeting strict targets often prevails over investment in training and developing skills (McBride, 2011). Therefore, limited access to training for part-time workers, who are usually women, in the public sector, could be more likely. As well as public sector cost cutting, austerity measures reduced overall public spending in the UK and consequently the welfare state. This places more emphasis on income support and childcare to the family, which encourages women to focus on domestic labour and consequently reinforces the male breadwinner model (Conley and Page, 2014).
SECTION FIVE: FEMINISATION OF THE MEDICAL PROFESSION

Four fundamental dynamics can be identified that inform the research questions and the way this research is approached. The first is the recent feminisation of the medical profession in England where gender segregation on both horizontal and vertical levels is evident. Secondly, medicine is a profession traditionally dominated by men so devaluation may have occurred since more women have entered. The third dynamic concerns working time, since the literature shows that women in professions often resort to working part-time hours due to the long hours culture, so are consequently disadvantaged when working part-time in terms of their career profession, training opportunities and subsequently their pay. Fourthly, this phenomenon of feminisation is taking place in a ever-changing context of the UK public sector, where the neoliberal actions of the state has been found to have a negative impact on women’s terms and conditions of employment, particularly during a period of economic austerity. This final section of the literature review brings together these areas of literature and applies them to what is known currently about the medical profession in England. This enables gaps in the current literature to be identified and potential research questions to be formulated.

Background and statistics

Even though women make up 77% of the NHS workforce (NHS Employers, 2018), men occupy more of the senior level roles (NHS Employers, 2018). NHS Digital statistics show women, particularly those of BAME status, tend to be clustered into lower paid and status roles, such as cleaning and administration (NHS Employers, 2018). For example, women workers make up 74% of the lowest NHS pay grade (Band 1) (NHS Digital, 2018c). In addition, only 6% of female NHS employees are doctors and dentists, compared to 22% of male NHS employees (NHS Employers, 2018). As mentioned earlier, there is also evidence of gender segregation within the nursing profession, where 88.6% of the NHS nursing workforce is female (Nursing Midwifery Council, 2018).
Despite countries having different healthcare systems and social contexts, the last 15-20 years has seen a notable increase in the number of women entering the medical profession across many countries around the world (Kilminster et al, 2007), such as: Canada (de Koninck et al 1997), Norway (Gjerberg, 2001) and Sweden (Riska, 2001). A recent piece of research conducted by the OECD shows that over 50% of doctors are female in nine of the thirty six OECD countries, with all OECD countries showing evidence that their medical professions had experienced feminisation (OECD Health Statistics, 2013). The OECD data also shows that the increased number of women joining medicine is on the rise since, on average, 44% of doctors across OECD countries were women, compared to 38% in 2000 (OECD Health Statistics, 2013).

As mentioned earlier, the number of female doctors has also increased in the UK over the last ten years and now 47.5% of licensed doctors are women (GMC, 2017a). The feminisation of medicine looks set to continue, as 58% of doctors in training are female (GMC, 2017a). These findings are a stark contrast compared to 1960 when women made up just 24% of the medical school intake in the UK (Centre for Workforce Intelligence, 2012). Khan (2012) argues that the medical profession has become feminised in the UK due to men opting to choose alternative subjects, such as law and business - where they can gain equally highly paid jobs in a much shorter time frame, and at the same time, female students are outperforming male students at A-Level and therefore represent a greater number of those meeting the entrance requirements of medical school. Thus, as Reskin and Roos (1990) argue, it appears the job queues and labour queues are changing within medicine that have led to the feminisation of the profession. Feminisation may have also been partly facilitated by entry to the profession being determined by universities, and not the employer, that has consequently allowed women to move up the labour queue more easily. Documented views via the media have revealed concerns expressed by several influential individuals of the Royal Colleges and Universities regarding the feminisation of the medical profession in the UK. Former president of the Royal College of Physicians, Carol Black, questioned how the profession would retain its influence after feminisation (BBC, 2004). This statement has since caused a multitude of headlines claiming that women
doctors are weakening the medical profession since women are more likely to work part-time so more doctors will be required in the future (BBC, 2004; McAleese, 2013).

Even though there has been an increase in female doctors, there are distinct gender differences and thus gender segregation across medical specialties. For example, male doctors continue to dominate the majority of hospital-based specialties, such as surgery, radiology, general medicine, emergency medicine and urology, both at consultant and specialty trainee level (NHS Digital, 2018a), whereas female doctors dominate the specialties of general practice, paediatrics, and obstetrics and gynaecology (NHS Digital, 2018a). Although it should be noted, this is most likely due to the generational “time lag” (McManus and Sproston, 2000), that consultants in obstetrics and gynaecology remain predominantly male and this may change once more female specialty trainees begin to qualify and gain consultant posts. Anaesthetics, obstetrics and gynaecology, and geriatric medicine appear to be attracting significant numbers of specialty trainees when comparing NHS Digital data from 2014 to 2018, with similar numbers of men and women now undertaking postgraduate training in anaesthetics; and significantly more women, yet fewer men, opting to undertake postgraduate training in obstetrics and gynaecology, and geriatric medicine. These disparities in medical specialty choices are not only based on gender differences. Statistics show that there is also segregation based on doctors’ location of primary medical education, since international medical graduates (IMGs) are overrepresented in the specialties of general psychiatry, obstetrics and gynaecology, paediatrics and histopathology (General Medical Council, 2012). Therefore, this raises the question of why certain medical specialties are feminising at a greater rate than others? This question is addressed through a review of the relevant literature in the following section.

**Gender segregation in the medical profession**

Gender segregation has always been present within the medical profession (Walby, 1988). Medicine is a unique profession in the sense that it has a “rich variety of career choices” (Elston, 2009). For example, in the UK there are currently around 80 specialty, and sub-specialty, choices for doctors to choose from (NHS Digital, 2018a). Despite
this, the most recent NHS Digital (2018a) data, described earlier, shows the workforce of medical specialties does not reflect the diversity of the specialty choices available, whereby many specialties are dominated by a particular gender. This is referred to as: horizontal gender segregation. A plethora of research has been conducted concerning why men and women choose different medical specialties, with reasons varying from personality to work-life-balance considerations. However the majority of the research has been conducted in the United States (Takeda et al, 2013) where the context of the medical profession is different to that of the UK as it is a profession set within the private sector. This section of the literature review aims to explore why male and female doctors may choose different medical specialties and highlight the gaps in the literature that this research aims to address.

Boulis and Jacobs (2010) compare three frameworks to explain why there are occupational gender differences amongst doctors within the American healthcare sector. The first of these is: ‘personal choice/different voice’. This framework states that “gender differences in the workforce stem primarily from differences in the choices that men and women make as they pursue education and paid employment” (Boulis and Jacobs, 2010, page 16). This outlook agrees that women choose to work fewer hours than their male counterparts in order to meet their family and domestic commitments. The ‘different voice’ aspect of the framework focuses on the inherent differences between men and women. The ‘different voice’ analogy claims that women are usually more caring and less competitive than men. So by applying this idea to medicine, the idea is that women are more likely than men to choose specialties that have high patient contact, and that higher earnings are less important to them.

The second framework used by Boulis and Jacobs (2010) is “institutional discrimination thesis” which “suggests that specific industry and organisational characteristics and the behaviours of other key groups in the health services workforce are responsible for many of the disparities between male and female physicians” (Boulis and Jacobs, 2010, page 18). This idea is built mainly from the views of Kanter (1977) and her work on ‘structural differences’, which focuses on the idea that the gender differences in the
workplace are based around the differences in power and status within the organisation. Institutional discrimination may arise from women receiving less mentoring support, few female role models and also assumptions regarding patients’ preferences may cause women to choose certain specialties. For example, it may be the assumption that male patients would prefer a male doctor to conduct a prostate examination. This framework differs from the first in the sense that it is not women’s inherent caring nature that causes the differences in occupations, but that the structure of the work causes women have to spend longer with patients.

The third framework is described as: ‘social change’ (Boulis and Jacobs, 2010), which has a similar ideology to Reskin and Roos’ (1990) dual queuing theory discussed earlier, in the sense that occupations become feminised when the status of the occupation declines. In brief, women enter professions at a greater rate when men are no longer interested. In addition, the jobs women enter in these professions tend to be lower paid, require fewer skills and career progression is limited (Bolton and Muzio, 2008).

Crompton and Lyonette (2011) also explain why horizontal gender segregation exists in the medical profession. In their research they analysed and compared the careers of women in medicine and accountancy, as they are traditionally male dominated professions that are experiencing feminisation. They recognise that in the 1980s and 1990s, scholars focused on the theories around “direct and indirect male exclusionary practices that effectively blocked women’s progression through the occupational hierarchy” (Crompton and Lyonette, 2011, page 232). However, Crompton and Lyonette (2011) argue that women now have more of an influence in their job choices. For example, Horst et al (2010) found that working hours now play a more significant role in determining which medical specialty a female doctor chooses. This may be the reason a third of the female participants in Crompton and Lyonette’s (2011) research changed from hospital medicine to general practice, since general practice is perceived as a specialty that allows more flexible as part-time working hours are readily available. Crompton and Lyonette (2011) also briefly analysed whether there are any discriminatory practices occurring within medicine to cause the occupational
segregation (corresponding with Boulis and Jacobs’ (2010) second framework: ‘institutional discrimination thesis’). They found that discriminatory practices are still present in the medical profession, but they are not blatant. For example, when a female consultant was asked why she failed to receive a promotion she replied with the following statement:

“I’m not into the old boys’ system, I’m not popular with the powers that be, and once I got to London I had no mentor, women lacked mentors and I’ve never ... schmoozing with the big wigs, I’ve never been able to schmooze, I’ve not been able to mingle with the male medical aristocracy, or the powers that be. (M18, female consultant)” (Crompton and Lyonette, 2011, p. 241).

Crompton and Lyonette’s (2011) research also highlights that most of the women interviewed had primary responsibility for domestic issues. This, again, emphasises that women need greater control over their working hours. As mentioned earlier, research suggests that both men and women are seeking for more control over their work-life-balance (Gatrell et al, 2014). This trend also appears to be the case for medical students and the younger generation of doctors, who treat lifestyle factors with great importance when choosing a medical specialty (Grigg et al, 2013; McAleese, 2013; Al-Nuaimi et al, 2008; Sanfey et al, 2006; Newton et al, 2005; Lambert et al, 2005). In the context of medicine, specialties that enable doctors to balance work and home-life are referred to as: “controllable lifestyle specialties” (Schwartz et al, 1989).

However, although “controllable lifestyle specialties” (Schwartz et al, 1989) are popular amongst both men and women, women are more likely than men to choose specialties that enable them to start a family more easily (Sanfey et al, 2006; Johnson et al, 1992; Al-Nuaimi et al, 2008). This may be due to specialty training taking place during the time period when women are most likely to consider having children (Mavriplis, 2010). This argument is further supported by Al-Nuaimi et al’s (2008) study, which looked at the factors influencing the specialty choices of medical students at the University of Manchester. They found that short working days ranked highly for both male and female medical students when choosing a medical specialty. However, women ranked the factors: ‘easily compatible with having a family’ and ‘flexibility with training’ more highly than their male counterparts.
When analysing the link between work-life-balance and medical specialty choice, it has been found that female doctors also opt for specialties that have shorter or more flexible training options (Redman, 1994). However, research by Al-Nuami et al (2008) shows that male medical students were more likely than female medical students to place importance on a shorter length of training when choosing their medical specialty. Therefore perhaps female doctors place more focus on the flexibility of the training rather than the duration, so they are able to balance work and family life.

It could also be argued that whether doctors are married to another doctor effects medical specialty choice, since the choices of a dual-doctor family has the potential to be more complex due to the added consideration of another person’s choices. These relationships will be referred to as: “dual-doctor families” (Sobecks et al, 1999) throughout this section. Sobecks et al (1999) found in the US that half of all doctors are married to another doctor. Also, they found that female doctors are more likely to be married to another doctor than male doctors. However the union of two highly ambitious and highly intellectual individuals may cause career decisions to become more difficult since a variety of unique factors need to be considered. For example, the geographical location of work available becomes an additional issue since both partners aim to be in close proximity to their home and family (McElvanna et al, 2013; Mavriplis, 2010). In addition, Sobecks et al (1999) also found that women in dual doctor families made different personal choices compared to women not married to another doctor. Dual doctor family women also felt their partner’s career took precedence over their own career and, because of this, tend to earn less than non-dual doctor family females (Sobeck et al, 1999; Hinze, 2000). Similarly, Johnson et al (1991) surveyed twenty-two dual-doctor families in the UK and found more than half of female doctors chose their specialty based on their partner and childcare, whereas only 5% of male doctors surveyed considered these factors when choosing their medical specialty. Therefore Johnson et al (1991) argue that, as a result of this, the male doctor’s career development in the dual-doctor relationship often took priority over their partner’s. Perhaps it could also be argued that men have the option to choose the more desirable specialties with a higher ‘prestige’ or ‘status’, since they do not have to consider working time issues to the same extent as women.
Many researchers have argued that the personality traits associated with each gender have an effect on medical specialty choices (Stilwell et al, 2000; Buddeberg-Fischer et al, 2003; Kiker and Zeh, 1998). Personality tests in these pieces of research have shown that women are more likely to choose primary care specialties due to their preferences for “feeling” and “introversion” (Stilwell et al, 2000). Meanwhile men are more likely to choose surgery due to their more “extrovert” personalities (Stilwell et al, 2000). However, an extensive review of the psychometric methods used to test the relationship between medical specialty choice and personality characteristics has shown a weak association (Borges and Savickas, 2002).

Due to the recent feminisation of the UK medical profession, Elston (2009) conducted an in-depth literature review to analyse why female doctors dominate certain specialties in the UK. Elston (2009) argues that doctors’ specialty choices are based primarily on how predictable the working hours are, and how much patient contact is involved in the specialty. Elston (2009) states that more female doctors choose general practice, paediatrics and psychiatry due to higher levels of patient contact and more predictable working hours. In contrast, men dominate the specialties of surgery and anaesthetics for the opposite reasons (as seen in Figure 3, page 54). However, it is important to note that Elston (2009) recognises that organisational changes may cause some specialties to shift quadrants and thus attract an increased number of doctors of the opposite gender.
Several studies have also highlighted the importance of role models in the specialty when doctors make their career choices (Wright et al, 2002; Burack et al, 1997). Burack et al (1997, page 534) found that doctors would often base their decisions by “trying on possible selves”, whereby they would imagine themselves in a specialty based on the role models in those specialties. There is also the issue that certain medical specialties, such as the male-dominated surgical specialties, may become “sex-typed” (Matthieu, 1992; Peters et al, 2015), which is difficult to reverse.

It is argued that horizontal gender segregation cannot be seen “as an isolated phenomenon” (Walby, 1988, p.7) but instead that the gendering of social norms, policies, and political forces also has an impact on the gendering of professions. Stratton et al (2005) found in the US that the gender discrimination doctors experienced, or observed, during medical school had an effect on their medical specialty choice. Although more women than men had experienced and/or observed gender discrimination at medical school, male doctors placed more emphasis on their experiences of gender discrimination when choosing their medical specialty, compared to women.
It should also be noted in this review that due to the shortage of doctors in the UK, the NHS requires a high number of international medical graduates (IMGs) to fill vacant posts. However, research suggests that IMGs often enter specialties that are less desirable (Fazel and Ebmeier, 2009). Fazel and Ebmeier (2009) aimed to find why psychiatry appears to be an occupational ‘ghetto’ for IMG doctors by analysing quantitative data from Modernising Medical Careers (MMC). They compared the number of applications to a specialty and the average annual salary for a consultant in that specialty and found that surgery offered the highest consultant salary and was the most popular specialty choice. However, psychiatry was the least popular amongst UK graduates. Despite this, psychiatry was the fourth most popular specialty amongst IMG doctors. Therefore it is apparent from this data that UK medical graduates have the tendency to apply for the specialty with the highest average consultant salaries. In brief, this research suggests that UK applicants are opting for the higher paid specialty positions, which have more options for private work, whereas those who have studied medicine overseas are taking the roles which are lower paid and thus less desirable to UK graduates. However, it should be noted that gender was not considered in this study.

Similarly Oikelome and Healy (2013) focussed on IMGs and their specialty choices. By conducting an analysis to see how gender and location of medical education intersect, it was found that “females are more likely to be discriminated against in the receipt of awards and discretionary points” (Oikelome and Healy, 2013, page 559) - which makes it difficult for them to enter their first choice specialty. Therefore, similarly to Fazel and Ebmeier’s (2009) study, they argue that IMGs are the most disadvantaged group with regards to specialty choice. In other research by Healy and Oikelome (2007) they again notice the disadvantages that IMGs face when trying to choose a medical specialty, since they are usually clustered into Specialty and Associate Specialist (SAS) grades. Although the research of Oikelome and Healy (2013) is silent on issues of nationality and ethnicity, their work in 2007 made more reference to intersection of gender, nationality and ethnicity. Therefore these three articles provide strong evidence that in the context of medicine, and specialty choices, location of primary medical degree
should be considered, and this is likely to be a proxy for the intersection of ethnicity and nationality from those conducting their degree outside of the UK to differ from those who have completed their medical degree in the UK.

Overall, it can be seen that there are gendered differences in medical specialty demographics. However whether this is due to individual choices, organisational and institutional factors, or a combination of reasons remains unknown. Since most research in this area has been conducted in the United States, it could be argued that the results should be treated with caution when applied to the UK, since both health systems are different in terms of privatisation and potential salaries. Therefore, there does appear to be a gap in the research regarding the UK context and the potential impact the state as the employer can have on medical specialty choices.

**POTENTIAL IMPLICATIONS OF THE FEMINISATION OF THE MEDICAL PROFESSION**

When discussing the outcomes of the feminisation of the medical profession, it may be useful to focus on the aspects of ‘medical’ and ‘profession’ separately as two issues are at play here. First in relation to the notion of profession, the issue is whether the high levels of autonomy, power and self-regulation (Evetts, 2014; Cruess et al, 2004) associated with a profession are still found when women become to dominate a profession? As discussed in the first section of this literature review, when a male-dominated occupation/profession becomes feminised, the status, salary and job security diminish (England, 1992; Kilbourne et al, 1994). Therefore, when a ‘profession’ is feminised – it could be predicted that the levels of autonomy, power and control of that profession would also decrease, perhaps creating a “semi-profession” (Etzioni, 1969). Evetts (2014) argues that the attributes associated with professions often do not apply when women work in those professions, mainly because of women’s assumed childcare and domestic roles in UK society.

Studying medicine traditionally confers a high amount of prestige, due to the high level of academic knowledge and skills to complete the work. Therefore, when “medicine” and “profession” are combined, this may be why the medical profession holds such high esteem and is often referred to as an “elite profession” (Walby and Greenwell,
1994). However, in the UK, the medical profession is under the monopsony of one organisation – the NHS – a public sector organisation. Therefore there is the added dimension of an elite profession that has become feminised, within a sector that is associated with a new public management style during an economic climate of post-recession and austerity, a context where much research shows women face negative impacts to their employment terms and conditions (Coffey and Thornley, 2009). The questions raised here are: is the medical profession immune to such diminishing of working conditions, because it is an ‘elite profession’, which requires a significant amount of academic qualifications and training? Or, because it is a profession confined to the public sector, will it face the same issues as other female-dominated, public sector professions – such as teaching (Conley and Jenkins, 2011)?

Applying the issues discussed so far in this literature review to the context of the UK medical profession highlights a number of interesting debates and gaps in the current literature. These issues require attention due to the increasing numbers of female doctors entering an occupational culture characterised by long working hours and high work intensification (Balme et al, 2015). It may be the case that, within the context of the medical profession in the public sector, there may be a set of unique issues unfolding that are contextually bound to the NHS.

As seen from the arguments earlier, women are generally more likely than men to work part-time and flexible working hours and this is the same in medicine (NHS Digital, 2014). Compared to other professions, the number of doctors opting to work part-time is still relatively low, as the most recent NHS medical workforce statistics available show that in the NHS 14% of medical staff (excluding GPs) work part-time, with 72% of part-time workers being female (NHS Digital, 2014). As expected, a low percentage (7%) of male doctors in hospital medicine work part-time hours compared to a slightly higher 22% of women working part-time in hospital medicine (NHS Digital, 2014). The statistics also show that male doctors are considerably more likely to work part-time at consultant level compared to other stages in their career (NHS Digital, 2014). Although this is the same case for female doctors, there is not as dramatic a difference in the number of part-time female consultants compared to the number of
part-time female registrars and specialty doctors. On the other hand, NHS Digital (2014) workforce statistics reveal that the majority of female GPs (approximately 70%) work part-time, compared to 28% of male GPs. These statistics highlight that part-time work is not only associated with gender but also doctor seniority and medical specialty.

It could be argued that there is an increase in the number of male doctors working part-time at consultant level so they can supplement their NHS salary with private sector work, where the rate of remuneration is higher. Due to the number of female doctors working part-time being more evenly spread across the doctor grades, this could indicate that women’s choices to work part-time are determined by additional factors that are different to men’s. This statistic could support the argument that women are more likely than men to work part time in order to take on childcare and domestic opportunities in the home. However, it is not possible to categorically claim that men choose part-time work to earn more money and women choose part-time work to achieve a more meaningful work-life-balance due to their gender on an individual level, since there is evidence that employed fathers are becoming increasingly more child-orientated when making decisions about their working hours (Gatrell et al, 2014). Instead, these statistics highlight that a range of intersecting factors, on a variety of levels, could be contributing towards men and women’s working time decisions. For example, it could be argued that it is the ingrained values of long working hours, that are synonymous with the male breadwinner model, either within the profession (Witz, 1992) or within NHS as a “gendered organisation” (Acker, 1990). Moreover, it may be the case that there are ‘inequality regimes’, which Acker (2006, page 443) describes as “work practices and processes that result in, and maintain, class, gender and racial inequalities within particular organisations”, present within the context of the medical profession.

Also, NHS employment practices and policies may be framed around the male breadwinner model, consequently making it difficult for attitudes to change regarding men and women’s working time (Burnett et al, 2013). Therefore, perhaps male doctors feel that it is perceived to be more acceptable to work part-time in order to earn more
money than it would be to spend more time at home with their children. In addition to this, there is also the general assumption that flexible working time arrangements are more accessible to mothers (Gatrell et al., 2014). It should be noted that men and women’s working time decisions are also shaped by government activities on a macro level. For example, as mentioned earlier, cutbacks on childcare provisions by the state can shape how much time women spend on childcare responsibilities and encourages women in employment to work part-time hours (Rubery and Grimshaw, 2003). Therefore the intersections of these dynamics at various levels of the employment relationship could all potentially play a role in the number of hours doctors choose to work. Another explanation could be that working hours are too long, similar to teaching (Conley, 2002), accountancy (Lewis, 2007) and midwifery (Prowse and Prowse, 2015) so women have little option but to work part-time as full-time hours are incompatible with a family life.

In addition, these statistics show that the choices relating to part-time work in the medical profession are not solely confined to gender. This is because the majority of part-time doctors are consultants across both genders. Therefore perhaps age and occupational seniority is a factor in the sense that consultants, who tend to be older, may opt for part-time work. This suggestion also links closely to Crompton and Lyonette’s (2011) research concerning female doctors who found that once qualified, female doctors were more likely to work fewer hours. Also, as Riska (2001) notes, the average retirement age is relatively low amongst doctors due to the high work intensification for the duration of their medical careers. Perhaps it could be that doctors work part-time later on in their careers as a transition into retirement whilst also still earning a wage. Therefore, in the context of the medical profession in the NHS, it may be the case that part-time working is not always to benefit the employer as Fleetwood (2007) argues.

In the United States it has been found that more doctors, of both genders, are interested in working part-time compared to the availability of part-time work (Boulis and Jacobs, 2010). This may explain why a considerable percentage of women choose to work part-time in general practice compared to hospital specialties, since it may be
the only, or one of a few, specialties that has accommodated flexible working practices. This also raises the question of whether those in hospital medicine, particularly women, do not have an interest to work part-time or whether the option is not readily available for them. Levinson and Lurie (2004) argue that once more women enter a profession, family-friendly conditions (such as part-time working hours) will grow. Therefore perhaps family-friendly working practices have evolved in the specialisms that have attracted women on a larger scale than those that have not.

Also, as Higgins et al (2000) explain, women in career part-time jobs are often likely to be stigmatised for working part-time, experience work-overload and to be placed on the ‘mommy track’ whereby career progression is limited. Therefore it may be that women in the male-dominated area of hospital medicine may feel as though there is not the option to work part-time and have a ‘successful’ career. Perhaps the same scenario is occurring in the UK?

A higher level of demand in the future for flexible working for doctors in the NHS could be expected due to the influx of women medical students and doctors. Gibson (1997) argues offering part-time work to doctors would actually be beneficial to the NHS because it would provide women who have had children an incentive to return to work. Also, women choosing to work flexible hours may “humanise the profession” (Riska, 2001) so male doctors also consider flexible working practices. It has been found in the United States that the specialties that have become feminised on the larger scales (such as primary care) have had to adapt and respond to the demand for flexible working more promptly than other specialties (such as surgery) that remain male-dominated (Boulis and Jacobs, 2010).

Although there has been much research into looking at the effects WLB practices have on gender and equality, there is no research looking at this within the context of doctors in the NHS. There is also a gap in the literature that both expresses the views and experiences of part-time doctors, and also the views of full-time doctors regarding doctors who work part-time. It may be the case that, for some doctors, part-time work is the “death of a career” (Higgins, 2000), whereas for consultants seeking part-time work in order to have the option to work in other sectors may be perceived in a more
optimistic light. Also, as Tomlinson (2007) notes, WLB and gender equality does not only concern the consequences for the majority of women that work part-time but also ensures that men and women have equal resources to make genuine choices about paid work and unpaid work.

This chapter shows that there are four main, interlinking literature themes that raise a number of issues that require further investigation within the context of the UK medical profession. The next chapter (chapter three) provides detail on the complex context of the medical profession in the UK, partly to assist in formulating research questions to address the issues raised in this literature review.
CHAPTER THREE

CONTEXT

INTRODUCTION
As discussed in the literature review, the feminisation of the medical profession is occurring in a context not only of changing patterns of women’s educational and career choices, and changing patterns of gender segregation, but also against a background of constrained public spending budget due to economic austerity measures following the recession in 2008. The NHS as an effective monopsonist purchaser of medically trained staff might therefore be expected to be under pressure to reduce cost in ways that might lead to devaluation along with other but more long-standing female-dominated public sector professions, such as teaching and nursing, which have arguably become devalued (Conley and Jenkins, 2011; Bolton and Muzio, 2008; Allan et al, 2008; Lane, 2004). These pressures might also be expected to have repercussions for policies and practices in relation to working time, a key issue for doctors and female doctors in particular, not only because of standard concerns over care but also because of the extreme and long hours culture in medicine.

Understanding the institutional and policy context is thus vital for any study of changes to professions and feminisation. However the medical profession is a complex context to research in this area for a number of reasons. Firstly, the medical profession is often described as an “elite profession” (Mathers et al, 2011; Walby and Greenwell, 1994) and has a rich history of prestige due to the high level of qualifications and training required to become a qualified doctor. This has meant doctors have also held a higher status in society (Kaba and Sooriakumaran, 2007). Therefore this elite status could perhaps protect the profession from devaluation or even veil its occurrence. Secondly, since the medical profession has recently become increasingly feminised, there is a generational “time lag” (McManus and Sproston, 2000) whereby the higher levels of the profession’s hierarchy have yet to see a marked increase of female consultants in some medical specialties. Therefore the lower levels within medicine’s hierarchy, that is the junior doctors, may be more likely to experience devaluation differently
compared to consultants and qualified GPs. Likewise, female doctors are segregated in certain medical specialties, such as paediatrics, and obstetrics and gynaecology. This raises the question whether the medical profession may become devalued in certain specialty areas only. Thirdly, the medical profession is also perceived as being more immune to government pay cuts and freezes compared to other public sector occupations and professions, as the profession has previously adopted strategies to deter threats to changes to employment terms and conditions (Exworthy et al, 2016). Therefore, as more women enter, it is uncertain if the medical profession would necessarily experience the same devaluation as other female-dominated public sector professions and occupations, such as teaching (Conley and Jenkins, 2011; Bolton and Muzio, 2008) and nursing (Lane, 2004; Allan et al, 2008).

This research goes beyond solely tracing any devaluation effects but seeks also to look at the impact that the actions of various actors and organisational infrastructures may have on doctors’ career choices and working lives, particularly how these actions and infrastructures affect female doctors. This includes considering the gendered implications of government and NHS employer policies and decisions, for example in relation to the way in which training programmes are structured, how pay is determined and how working time is organised. It is well known that the role of a doctor inherently equates to working long, unsociable hours, and requires many years of intense training to reach the highest echelons of the medical career hierarchy. However, the way certain medical specialties are organised, in terms of working hours and training time, may make them more attractive to female doctors, since women still hold the main responsibility for childcare and domestic labour (Lyonette and Crompton, 2015).

In order to inform the research questions, and provide background to support the empirical data, this chapter aims to clarify and explain the unique context of the medical profession in England. There are four main contextual issues that are discussed here that relate to the main research themes outlined in the literature review (chapter two). The first explains how the medical profession is organised and the structural differences in doctors’ employment relationships, depending on the
stage of the doctor’s career. It is important to note here that this research is looking at the employment experiences of both specialty trainee doctors in anaesthetics, general practice and paediatrics; and also those doctors who have qualified as consultants or GPs. The employment relationships of these latter two groups are very different, so are subsequently discussed separately throughout this thesis. This is to highlight possible variations in the responses to, and implications of, feminisation between the different career stages and medical specialties.

The second contextual issue is the medical training system, with a particular focus on the training programmes of anaesthetics, general practice and paediatrics. Each medical specialty has its own style of training programme, thus each has differing assessment styles, work locations, training demands and working hours. With a multitude of specialties for doctors to choose from, it may be that training programme structures are gendered, and consequently shape doctors’ career choices and working lives.

The third contextual issue is the shaping of doctors’ employment terms and conditions, such as pay determination, working time arrangements and issues surrounding maternity. Similarly to the employment relationship, pay is also determined differently at the various stages of a doctor’s career and also varies depending on the medical specialty. Outlining doctor’s pay determination is necessary because previous research suggests that when a profession becomes increasingly feminised, the salary reduces (England, 1992; Kilbourne et al, 1994). Also, in the public sector, there have been pay cuts and pay freezes to other public sector professions and occupations during times of austerity. Therefore by clarifying how pay is determined, this identifies any possible impact on female doctors and shapes how the research questions are addressed. Due to more women entering the profession, it is highly likely that maternity leave and pay policies will be important, and issues surrounding working time. These issues came to the fore during the research due to the coincidence of timing between the fieldwork and the junior doctors’ dispute over a new contract.
This leads to the fourth contextual issue concerning the state’s current roles within the NHS employment relationship of doctors. As highlighted in the literature review, the state has conflicting roles between being the ‘model employer’ and adhering to a strict budget, particularly during times of austerity (Hyman, 2008; Coffey and Thornley, 2009), as well as other roles, such as the protector of standards, promoter of social citizenship guidelines (Hyman, 2008), and also adhering to the public sector duty (Conley and Page, 2018). After the economic recession in 2008, the UK entered an austerity programme, which has had significant impact on the state’s conflicting roles as an employer of doctors but also a manager of public expenditure and of public services delivery.

Prior to the discussion of these four key contextual issues, it is important to also briefly address the key issues surrounding the formation and evolution of the NHS as a public sector organisation. The NHS was formed on the 5th July 1948 by the Labour party Health Minister, ‘Nye’ Bevan. Bevan’s vision was to provide a healthcare service, free at the point of delivery for all. Therefore this meant the state had the full, centralised control of hospitals, instead of local authorities, and that healthcare would be funded by taxation. Many contested the plan, such as the British Medical Association and Lord Latham (leader of the London City Council). They argued it was not in the interest of patients to pass responsibility to the state, as they felt the UK had some of the “finest hospitals in the world”. The vast majority of doctors also did not want to become employees of the state, as they feared a loss of clinical freedom and financial reward due to less private work (Klein, 1983). The NHS could not function without doctors, so they had strong negotiating power which meant Bevan made a number of concessions, such as keeping the option of private healthcare (although only consultants could administer it) and GP surgeries remained to operate as privately owned businesses.

Since the formation of the NHS, the UK population has grown and people are living for longer (ONS, 2018). Therefore the financial pressures are more than when the NHS was originally formed. The Thatcher government introduced reforms to operate the NHS more like a private sector organisation that have continued through subsequent political party policies, with the view of reducing public spending. Part of this is the
privatisation of NHS provisions and contracts, particularly during the Labour government of the 2000s (Greener, 2015). The Kings Fund (2018) review shows that the privatisation has been increasing, but it is difficult to tell at what rate due to changing definitions of ‘private sector providers’ within the Department of Health accounts. Although consultants have the option to practice privately, and GP Partners are effectively self-employed, the NHS employs the vast majority of doctors and/or the NHS shapes doctors’ employment relations. Therefore, for the purpose of this thesis, doctors are described as being ‘largely’ under the monopsony of the NHS.

THE STRUCTURE OF THE MEDICAL PROFESSION AND EMPLOYMENT RELATIONSHIPS

There are many actors involved in a doctor’s employment relationship, and the structure of this relationship changes at the different stages of a doctor’s career. However the state, as the employer, underpins the relationship and consequently impacts on doctors throughout the entirety of their career within the public sector. This section is concerned with what impact the employment relationship may have on the devaluation of the profession and doctors’ working lives more generally. Firstly, the typical medical career pathway is outlined, then the employment relationships of specialty trainees, consultants and GPs – who are the focus of this research – are explained.

The doctors’ training system in England is lengthy, beginning with four to six years studying at medical school. After graduating from medical school, doctors in England are then required to complete two years of foundation training. Foundation training is set out by the Academy of Medical Royal Colleges and consists of a combination of training in medicine and surgery, mainly in hospital settings. After this, if the foundation doctor chooses to specialise, they then apply for specialty training in a medical specialty of their choice. Specialty training structures vary considerably in areas such as training length, application style, assessment processes and location of work. The training structures of the specialties included in this research are discussed in more detail later in this chapter.

7 Since August 2017 the inclusion of a community placement, usually within a GP Practice, is now a compulsory part of the foundation training.
During foundation and specialty training, doctors are collectively labelled as ‘junior doctors’ and are employed by Health Education England (HEE). Even though HEE is a part of the NHS structure, it is not strictly an NHS Employer as it is a Non-Departmental Public Body (NDPB). Its main responsibility is to “support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place” (HEE, 2017). So, while trainees are employed by HEE, they physically work at NHS Employer sites, often moving every six months to a different NHS Trust. Most of their pay and employment conditions are determined by the general contract for junior doctors, though their working time patterns are shaped by the specific Trust or GP practice where they are working. To support specialty trainees during their training, each trainee is assigned an educational supervisor, who is a trained relevant consultant/qualified GP. Their role is “to be responsible for the overall supervision and management of a specified trainee’s educational progress during a clinical training placement or series of placements” (GMC, 2015, page 21). Educational supervisors have a complex role spanning from education management to assisting with trainees’ career planning, and are usually the first point of contact should any work-related issues arise. Once specialty trainees complete their training programme, they receive their Certificate of Completion of Training (CCT) – a legal requirement to practise as a consultant or GP. Once working in a consultant post, doctors at this level are then employed by an NHS Employer and consequently have a different employment contract compared to “junior doctors”.

GP Partner(s) are responsible for recruiting and employing salaried GPs, whose employment contracts must meet the minimum terms and conditions as agreed between the DH, the NHS confederation and the General Practitioners Committee (GPC). The minimum terms and conditions to be met include the definition of full-time working hours at 37.5 hours per week, 40 days holiday (including public holidays), a minimum FTE salary of £56,525, and the right to access statutory maternity rights and the NHS maternity allowance. In contrast, because GP Partners are classified as self-employed, they do not qualify to abide by the European Working Time Directive (EWTD) so can work over 48 hours per week. Nor are GP Partners covered by sick pay
or maternity pay benefits that salaried GPs, and consultants on NHS contracts receive. The typical doctor’s career pathway is highlighted in Figure 4 below.

**Figure 4: Typical career pathway of doctors**

![Diagram of the typical career pathway of doctors](image)

<table>
<thead>
<tr>
<th>Medical Student</th>
<th>Foundation Doctor</th>
<th>Specialty Trainee</th>
<th>Consultant/ Salaried GP/ GP Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-6 years training at medical school</td>
<td>2 years training, employed by HEE region</td>
<td>3-8 years training, employed by HEE region</td>
<td>Employed by NHS Hospital Trust (consultants), GP Practice (salaried GPs) or self-employed (GP Partners).</td>
</tr>
</tbody>
</table>

Source: adapted from Health Education England (2014)

In addition to the varying employment relationships during a doctor’s career, there are actors other than the state and HEE who are involved in, and shape, these relationships. The trade union for doctors, the British Medical Association (BMA), also shapes the employment relationship. For example, the BMA have various roles from

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8 Doctors may become a Specialty or Associate Specialist doctor, known collectively as SAS doctors, rather than becoming a consultant. SAS doctors are required to have completed at least three years of postgraduate training (including Foundation Years training). As SAS doctors were not included within this research, they were omitted from Figure 4 to reduce complexity of the diagram and discussion.
negotiating with the state on issues surrounding doctors’ pay and working conditions, to providing employment support to members. The most recent statistics show the BMA has over 160,000 members, with women making up almost half of its members\(^9\).

With the number of female doctors rising, the BMA’s role as a trade union with a vested interest in issues that impact female doctors has become increasingly important, as discussed in further detail later in this chapter, particularly in its role with negotiating with the state should the profession experience devaluation, similarly to nursing and teaching. Other influential actors in doctors’ employment relationships are the medical Royal Colleges. Each medical specialty has its own respective Royal College, which is responsible for designing and setting training programme standards and structures. However the General Medical Council (GMC) assesses the overall delivery of medical standards.

It can be seen that doctors’ employment relationships are both complex and unique compared to other professions, even those within the public sector. It is important to highlight this, especially in terms of devaluation, because different doctors could be impacted differently at various stages depending on their employment relationship. For example, the state may choose to make changes to junior doctors’ employment contracts but consultants’ contracts are not necessarily affected. Or the state may perhaps target qualified GPs’ pay but not that of hospital consultants. Therefore these relationships have been explained here to inform the research questions and also to determine how the medical profession may be experiencing devaluation. In addition, clarifying the differing employment relationship actors also highlights the possible impact on female doctors, since they make up the majority of junior doctors (including specialty trainees) and are the main focus of this research.

**MEDICAL TRAINING PROGRAMMES**

Medical specialty training programmes can differ significantly, in terms of training length, the application process, geographical mobility requirements and modes of assessment. Most training programmes last around six to eight years, full-time.

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\(^9\) Data on the gender breakdown of BMA members is not publically available. The BMA provided the researcher with this data on 20th October 2015.
However general practice is unique and has a much shorter training period of three years. A specialty trainee’s requirement for geographical mobility also varies depending on specialty. General practice is a specialty where trainees can work in the same GP Practice for the majority of the duration of their training. In contrast, hospital-based specialties often require trainees to change hospital within their HEE region, approximately every six months, thus having less geographical stability, particularly if the region’s area is geographically large. As well as sitting examinations, specialty trainees are also required to self-assess through the online EPortfolio during their training as a means for their educational supervisor to monitor their progress throughout training. To provide a clearer understanding of the specialties involved in this research, each specialty is discussed in turn in this section.

**TRAINING STRUCTURE - ANAESTHETICS**

Trainees specialising in anaesthetics have the option of two routes when entering their specialty training. One is the core anaesthetics route and the other is the Acute Care Common Stem (ACCS) anaesthetics route. Both routes consist of four levels of training (basic, intermediate, higher and advanced). However the ACCS route takes longer as it includes an additional year of training during basic level training, but it enables anaesthetists to be qualified to work within intensive care units (ICU). Trainees specialising in anaesthetics apply at the beginning of their training to enter two, or three if choosing the ACCS route, years of basic core training. These years are referred to as CT1, CT2 and CT3. In order to progress onto the intermediate level of training, anaesthetics trainees are required to reapply for their training number and complete a Primary FRCA (Fellowship of the Royal College of Anaesthetists) examination. After completing intermediate level training specialty training (ST3 and ST4), anaesthetics trainees then sit their final FRCA examination to progress to higher-level training, which is two years in length (ST5 and ST6). Following the Final FRCA, trainees then progress to advanced level (ST7) when they are given the opportunity to specialise in a certain area of anaesthetics, if they wish to do so. Otherwise, trainees complete a year of ‘general duties’ within anaesthesia to prepare them for a future consultant post.
Anaesthetics training should be completed within seven years, full-time. Training will inevitably take longer for trainees working less than full-time (LTFT). However, how much longer is dependent on how much of the training programme can be accelerated. It should be noted here that anaesthetics trainees are required to be trainee members of the Royal College of Anaesthetists for the entirety of their training programme, at a cost of £165 per annum (RCA, 2018). Trainees in anaesthetics are also required to pay for their examinations each time they are sat, with fees ranging from £300 to £600 per examination (for 2018/2019 year).

**TRAINING STRUCTURE - PAEDIATRICS**

General paediatrics is a ‘run-through’ training programme where trainees apply only once for access to the training programme, which takes eight years to complete if working full-time. There are a total of three levels of paediatrics training – levels one, two and three. During level one, trainees are required to pass a series of Membership of the Royal College of Paediatrics and Child Health (MRCPCH) examinations. These examinations include three theory examinations and a final MRCPH Clinical Examination, once the trainee has passed the three theory examinations. It is expected that trainee paediatricians successfully complete at least two of the three theory examinations before ST3, and all four examinations before progressing onto level two of the training programme. Level two training consists of two years training (ST4 and ST5) and involves twelve months in general paediatrics, six months neonatology and six months working within community paediatrics. The final level of training, level three, is another three years of training beginning with year ST6, when there is the option for trainee paediatricians to competitively apply to sub-specialise in one of seventeen sub-specialties. Specialty trainees who choose to sub-specialise are required to apply for their sub-specialism and if successful receive a new training number and will normally need to relocate to the national training centre.

Paediatrics training is ‘trainee-led’ and ‘competency based’ so trainees are also assessed by their educational supervisor via the online EPortfolio tool throughout the training programme. Once completing ST8, paediatrics trainees then receive their CCT to practice as a consultant paediatrician. Paediatrics trainees are required to become a
member of the Royal College of Paediatrics and Child Health (RCPCH) at a cost of £208 per annum (as of August 2018 if including archives). In addition to an annual membership fee, they are also required to pay an annual training fee of £217, if working full-time, and £130 if working less than full-time; and also examination fees ranging from £310 to £525 per exam (RCPCH, 2018).

TRAINING STRUCTURE - GENERAL PRACTICE
The training programme length for general practice is much shorter than paediatrics and anaesthetics, lasting three years in total, after the two years foundation training. During this time, the trainee will be based at the same GP practice for the majority of their training in a GP registrar post, which the trainee can choose as being close to their home. General practice trainees are also required to complete a hospital specialty post (Sp). The duration of this post is dependent on the HEE region’s guidelines, usually six months in total, but the duration must not exceed the Royal College of General Practitioners (RCGP) guidelines of a maximum of twelve months. General practice training is a run-through programme, so the trainee only applies once for the entire duration of the three-year training programme.

Similarly to anaesthetics and paediatrics, training progress is assessed through examinations and self-assessment, set out by the Royal College of General Practitioners (RCGP). The examination for general practice consists of three components. The first is an Applied Knowledge Test (AKT), which is completed during, or after, ST2. The second is a Clinical Skills Assessment (CSA), which has to be completed towards the end of training in order to carry out general practice independently and safely after training. The third examination is through the assessment method of Work Place Based Assessments (WPBA), which takes place every six months between the GP trainee and their educational supervisor. A WPBA is based partly on the self-assessment of the GP trainee, using their EPortfolio to successfully display to their ability in the thirteen professional competencies as set out by the General Medical Council (GMC). The trainee’s educational supervisor assesses whether the trainee can continue with the programme depending on whether a suitable number of the competencies have been met through the evidence the trainee
provides. Similarly to paediatrics and anaesthetics, GP trainees are required to become members of the RCGP during their training at a cost of an initial one-off payment of £273.40 (RCGP, 2018) and £399 per annum if working full-time, or £199.50 per annum if working less than full time, or on maternity/paternity/adoption leave. In addition, GP trainees are also required to pay to sit their examinations.

**SPECIALTY TRAINING PROGRAMME CONCLUSION**

It can be seen from the training programme structures outlined above that specialty trainees have large workloads, costly membership and examination fees, and can work during unsociable hours. Specialty trainees are scheduled to work a maximum 48-hour week to comply with Regulation 4 (1) of the Working Time Regulations (WTR) (1998), as a part of the European Union legislation - the European Working Time Directive (EWTD). Regulation 4 (1) of the WTR (1998) states that:

> "a worker’s working time, including overtime, in any reference period which is applicable in his case shall not exceed an average of 48 hours for each seven days”.

Regulation 4 (1) was not originally imposed upon specialty trainees in the UK because the government feared the NHS would not cope with the sudden reduction of specialty trainee working hours. Therefore the Regulation was gradually applied to specialty trainees over a five-year period. From 1st August 2004 trainee doctors were allowed to work a maximum of 58 hours per week, decreasing to 56 hours per week by 2007 and finally to the latest reduction of a maximum 48 hours per week in August 2009. However it has been reported that doctors often work over this maximum limit (BMA, 2015). In addition to this, specialty trainees are also required to complete work during their training programme to complete the programme and to also boost their career opportunities in the future. Additional work includes revising for exams, audits, conducting research, writing publications, attending conferences, reading up on the latest medical developments, providing teaching sessions and completing their EPortfolio. Hospital-based specialties and general practice have different types of working hours. Although trainees in both specialties are normally scheduled to work
48-hours per week, these hours are at differing times during the week. General practice trainees usually work during the day on Monday through to Friday, whereas paediatric and anaesthetics trainees can work nights and weekends. However specialty trainees are likely to receive days off during the week when working weekends or following nightshifts. All specialty trainees are entitled to a certain amount of paid study leave. This entitled amount is one day per week for teaching, during university term time, and time for trainees to sit examinations. For all other types of study leave trainees must apply for a funding grant via their local HEE region. It should be noted that additional types of study leave are not an entitlement, so it is not always necessarily granted. It could also be argued that the monetary costs associated with examinations and Royal College membership may also add a financial burden to an already busy work-life and long working hours. In summary, each specialty’s training structure is different in terms of the way it is examined, its length, application process and geographical mobility. These differences have been summarised in Table 1 below.

**Table 1: Summary of specialty training programmes**

<table>
<thead>
<tr>
<th></th>
<th>Anaesthetics</th>
<th>General Practice</th>
<th>Paediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run-through training programme</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary work location / geographic mobility</td>
<td>Hospital (rotate place of work every six months)</td>
<td>GP Practice (same place of work throughout training, except six months in a hospital post)</td>
<td>Hospital (rotate place of work every six months)</td>
</tr>
<tr>
<td>Number of years training (full-time)</td>
<td>Seven years</td>
<td>Three years</td>
<td>Eight years</td>
</tr>
</tbody>
</table>
EMPLOYMENT TERMS AND CONDITIONS

Due to the complex employment relationships mentioned earlier, doctors are paid differently depending on the stage they are at in their career. Foundation Year (FY) doctors and specialty trainees are covered by the junior doctors’ contract, whereas hospital consultants and salaried GPs have their own contracts; and GP Partners are essentially self-employed.

The changes to doctors’ employment terms and conditions have mirrored changes to the political economy. During the Conservative government rule, independent pay review bodies were introduced for certain professions within the public sector, such as doctors, teachers and nurses. The introduction of independent pay review bodies was an attempt to replace collective bargaining, as they would be responsible for determining annual changes to pay to be in line with inflation and were portrayed as encouraging fair pay. However, it should be noted that even though pay review bodies limit collective bargaining power, they do not remove it completely as recommendations are considered prior to pay negotiations (White and Hatchett, 2003).

The level of NHS doctors’ pay is partly determined by the Doctors’ and Dentists’ Review Body (DDRB), which is an independent body introduced during the late 1950s following a decade of pay disputes, in the attempt to curb collective bargaining. The DDRB reviews doctors’ pay annually, and makes recommendations to the government regarding doctors’ pay. The Thatcher / Major Conservative governments of the 1980s and most of the 1990s saw the government encourage actions from pay review bodies that were inline with the economic status of the country. For example, in 1986 where there was economic growth, pay review bodies were encouraged to reward certain skills and professionals working in certain geographic areas (Bach and Winchester, 1994). However, during times of economic decline, the government puts downwards pressure on pay review bodies and has put in place pay limits in the attempt to reduce salary costs (Hatchett and White, 2003).
When the ‘New Labour’ government was elected in May 1997, there was a shift towards focus on the terms and conditions of public sector workers, which was the beginning of numerous ‘modernisations’ to pay and contracts – particularly doctors. New Labour’s plan was to recruit and retain “the best people” (Cabinet Office, 1999). However, the government’s rhetoric and reality did not match, and in the early 2000s the Labour government, similarly to their Conservative predecessor, put pressure on pay review bodies to limit pay increases by saying sharp increases to pay would mean spending would be taken away from public sector resources and that taxes would have to be increased to cover rising salary costs (Hatchett and White, 2003).

The New Labour government also made significant changes to consultant contracts in 2003, and GP contracts in 2004. The aim of the changes to consultant contracts was to ensure all consultants in the UK were encompassed by the same contract, with a focus on how consultants spent their working time to ensure they prioritised NHS work before private work (Jacques, 2013). To encourage consultants to remain working predominantly for the NHS, pay increased dramatically with full-time consultants receiving a 24% increase at the bottom of the pay scale, and a 28% increase at the top (Jacques, 2013). Therefore the changes did face criticism from MPs as they were seen as a “dreadful return on public money” (O’Dowd, 2013). The most notable change to GP contracts was the removal of the requirement for GPs to administer out-of-hours care. The contract effectively cut pay by 6%, but GPs no longer had to conduct work at the weekend or evenings. This change saw nine out of ten GP practices opting out of administering out of hours care (BBC, 2007). The negotiations were described as “a bit of a laugh” by Dr Fradd who was part of the BMA negotiating team, as he could not believe the generosity of the UK government as pay was decreased by just 6% for such a considerable cut to their working hours (Riggulsford, 2013). In addition, GPs were able to top up their earnings by hitting targets under a performance-related-pay bonus scheme (BBC, 2007). This caused much controversy at the time, with the view that this would place increased pressure on hospitals, particularly A&E, during unsocial hours. However a recent publication by the King’s Fund think tank reports there is no evidence to suggest this has been the case (Lind, 2014). Consultant and GP contracts are currently undergoing a review under a new Conservative government during a
prolonged period of austerity measures, which are discussed in further detail later in this section. Moreover significant changes have been made to junior doctors’ contracts, which are again discussed later.

It should be noted here that during the ‘New Labour’ government, the European Union introduced the Working Time Regulations (WTR) in 1998, under the European Working Time Directive (EWTD) to primarily protect the health and safety of employees. The main function of the EWTD is to limit working hours to 48 hours per week (unless an employee chooses to opt-out). It was deemed unfeasible by the government to reduce doctors’ working hours to 48 hours straightaway, as they had typically been working 90-100 hours per week (Bowhay, 2008). In addition, the NHS relied on doctors being available in the hospital during ‘on-call’ hours. Even though doctors were resting and worked as and when required during ‘on-call’ the European Court of Justice ruled that doctors’ ‘on-call’ hours were classified as working hours, even when resting as they were present at their site of work with the view of providing their professional services. The WTR were gradually applied to trainee doctors, since a dramatic reduction was not feasible. From 1st August 2004 trainee doctors were allowed to work a maximum of 58 hours per week, decreasing to 56 hours per week by 2007 and finally to the latest reduction of a maximum 48 hours per week.

This stark change to doctors’ working hours caused disagreement between the government, medical organisations, doctors and also the general public. For example, one main opponent to the EWTD was former Conservative Prime Minister David Cameron. On 23rd January 2013 Cameron gave a major speech in London regarding Britain’s position in the EU, emphasising his views that:

“Countries are different. They make different choices. We cannot harmonise everything…it is neither right nor necessary to claim that...the working hours of British hospital doctors to be set in Brussels irrespective of the views of British parliamentarians and practitioners” (Cameron, 2013).
Certain medical associations also disagreed with the implementation of the EWTD. For example, The Royal College of Surgeons of England claimed the NHS is now in “a mess” (Black 2009, p.259) especially with regards to doctors’ training since “the definition of working time also includes any period during which the worker is receiving relevant training” (Sargeant and Lewis 2010, p.225). However, on the supporting side of the EWTD is the BMA as they feel the 100 plus hours doctors were working prior to the directive were dangerous to both themselves and their patients.

This next section aims to outline the fundamental aspects of doctors’ employment terms and conditions to highlight areas where there could potentially be gendered implications. The way in which doctors’ employment terms and conditions are determined and structured appears to be largely dependent on the political economy.

SPECIALTY TRAINEES’ EMPLOYMENT TERMS AND CONDITIONS

Specialty trainees are employed under the junior doctors’ contract, which is reviewed by the DDRB annually. During the time this research was conducted, changes were imposed to their employment contract by the Department of Health. To briefly summarise (for more details see chapter six, part three), the main proposed changes at the time of data collection were:

- The removal of automatic annual pay increments
- Reduction of the unsocial hours premium pay
- A narrowing of the working hours classified as ‘unsocial’, whilst increasing working hours over the weekend

These changes and the current contract are discussed in further detail later in this chapter and within Chapter Six. During the time of data collection, a number of academics researched the impact of the changes to the junior doctors’ contract on various aspects of employment, such as morale, medical specialty choices and the pay. Beesa et al (2016) conducted interviews with 20 junior doctors, mainly FY doctors, to look at whether the proposed changes to their contract had reduced morale. They found that morale had dropped amongst the group studied. However the authors
admit their results cannot be applied to the whole population of junior doctors, as the sample was chosen through their own social networks, most of who were activists against the contract changes. Spooner et al (2016) also conducted research on 816 FY doctors to assess whether the contract changes had affected their planned career paths. They found the majority of respondents were moving away from acute medical specialties (i.e. A&E and surgery) towards community-based specialties (i.e. general practice) because of the contracts increasing unsocial hours work, which is not a contractual requirement for GPs. McKay et al (2016) also expressed their concerns with the proposed contract, as the proposed new contracts would not allow doctors to determine their working hours, and how these are distributed across the week, which is likely to lead to reductions to their salaries.

Despite significant changes to the contract, specialty trainees’ maternity leave and pay remains unchanged under the revised contracts. Specialty trainees can have up to 52 weeks maternity leave, from the 11th week before their baby is due. Pregnant specialty trainees receive maternity pay stipulated by NHS Employers. This is better than the UK’s statutory amount, if trainees qualify for the ‘NHS Scheme’, which is a contractual entitlement if a trainee has worked for, or within, the NHS for 12 months or more. Under the NHS Scheme, trainees can earn eight weeks full pay (minus any receivable statutory minimum pay), eighteen weeks at half pay (plus any statutory minimum pay providing the total pay does not exceed their usual full pay), and thirteen weeks paid at the statutory minimum (NHS Employers, 2017). This means that specialty trainees receive an additional two weeks at full pay compared to the statutory amount and 18 weeks at half pay not provided by statutory entitlements. So, from this viewpoint, maternity leave and pay both contribute to the vision that the state is the ‘model employer’ of female doctors compared to the private sector.

Specialty trainees also have the option to carry out their training on a Less Than Full-Time (LTFT) basis. There are eligibility criteria a specialty trainee must meet to apply for LTFT training. These criteria have been ranked in terms of importance by the employer and have been split into two categories, with category one applicants treated as ‘priority’. Category one criteria are: disability or ill health (this may include
IVF programmes), responsibility for caring for children, responsibility for caring for ill or disabled partner, relative or dependent. Category two consists of reasons surrounding further study for courses outside of specialty trainees’ medical training programme, such as postgraduate training (NHS Employers). Even though the option to work less than full time is available, there are still fairly strict criteria to meet.

**CONSULTANT PAY AND CLINICAL EXCELLENCE AWARDS (CEAs)**

Hospital consultants have separate contracts to junior doctors (including specialty trainees) and salaried GPs, so their pay structures are also different. Consultants’ pay thresholds increase as the number of years completed as a consultant increase. In addition to their annual salary set out in their employment contract, consultants can also apply to receive an additional payment each year in the form of a Clinical Excellence Award (CEA). CEAs recognise and reward NHS consultants and academic GPs who perform above and beyond the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions. Since there are a limited number of awards available, the process is very competitive and requires doctors to self-nominate for an award.

The application process takes place once a year, with the decision being made the following year. Consultants apply for an award level, depending on whether they currently hold an award and what award level they have achieved in the past. The monetary value of CEA awards ranges from £3,016 to a maximum of £77,320 (as of 2018). There are currently twelve award levels in total, with each level offering an increment in award payment. However, as the award amount increases, the amount of awards available decreases. Awards can be allocated at a local employer committee, or national committee, depending on the level of the award. Local awards are levels one to nine, and levels nine to twelve (bronze, silver, gold and platinum respectively) are awarded on a national basis but there are fewer available. Details of CEA payments can be seen in Table 2 below.
Table 2: 2018 Clinical Excellence Award levels and payment amounts

<table>
<thead>
<tr>
<th>Award Level</th>
<th>Amount awarded by local committees</th>
<th>Amount awarded by Advisory Committee on Clinical Excellence Awards (ACCEA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>£3,016</td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>£6,032</td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>£9,048</td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>£12,064</td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>£15,080</td>
<td></td>
</tr>
<tr>
<td>Level 6</td>
<td>£18,096</td>
<td></td>
</tr>
<tr>
<td>Level 7</td>
<td>£24,128</td>
<td></td>
</tr>
<tr>
<td>Level 8</td>
<td>£30,160</td>
<td></td>
</tr>
<tr>
<td>Bronze or Level 9</td>
<td>£36,192</td>
<td>£36,192</td>
</tr>
<tr>
<td>Silver or Level 10</td>
<td></td>
<td>£47,582</td>
</tr>
<tr>
<td>Gold or Level 11</td>
<td></td>
<td>£59,477</td>
</tr>
<tr>
<td>Platinum or Level 12</td>
<td></td>
<td>£77,320</td>
</tr>
</tbody>
</table>

The BMA and other research argue that CEAs are unfairly distributed, as women and IMG consultants are in receipt of fewer awards (Abel and Esmail, 2006). However Exworthy et al’s (2016) review of 53 submissions made by medical professional bodies following a review of CEAs by the DDRB in 2010, found that the majority of submissions stated CEAs were distributed equally and fairly.

SALARIED GP’S AND GP PARTNER’S TERMS AND CONDITIONS

Following CCT of GP training, GPs often choose between a salaried GP role, and GP Partner role. Salaried GPs do not have a pay scale, but salaried GPs are recommended to earn a minimum of £56,525 and a maximum of £85,298 per annum (as of 2017-18). It is up to the employer (the GP Partner) to decide how much a salaried GP should be paid depending on their working hours and workload. Salaried GPs are employed through a contract specific to their employer. As mentioned earlier, in August 2004 a
set of minimum terms and conditions were agreed that employers of salaried GPs should follow. One of these terms and conditions relates to maternity pay, which is stipulated by NHS Employers. Salaried GPs can qualify for the ‘NHS Scheme’, which is a contractual entitlement if a salaried GP has worked for the NHS for 12 months or more. Under the NHS Scheme, salaried GPs can earn eight weeks’ full pay (minus any receivable statutory minimum pay), eighteen weeks at half pay (plus any statutory minimum pay providing the total pay does not exceed their usual full pay), and thirteen weeks paid at the statutory minimum (NHS Employers, 2017).

GP Partners are not employed through a NHS contract. Instead GP Partners act as the employer of a ‘small business’ - the GP Practice. GP Partners usually enter a partnership agreement with one, or more, GP Partners and agree their employment terms and conditions together, whilst also meeting legal requirements. Although GP Partners’ pay is dependent on the amount of profit their GP Practice makes, on average GP Partners earn £101,500 per annum (HSCIC, 2015).

THE MULTIPLE ROLES OF THE STATE AND MANAGING THE NHS DURING A TIME OF ECONOMIC AUSTERITY

The state, as an employer, has conflicting interests between being perceived as the ‘model employer’, fulfilling, for example its equality obligations under the Public Sector Duty (Conley, 2016), and operating within a strict economic budget (Hyman, 2008; Coffey and Thornley, 2009). When a country’s economic conditions deteriorate, this tension becomes strained and, it is argued, capitalist logic prevails (Hyman 2008; Conley and Page, 2018). In brief, meeting constrained budgets and saving money is more important than being the ‘model’ employer. This is the current situation in the UK. Post-recession since 2008 has seen public spending dramatically cut, which has had an impact on many public sector jobs. The entire public sector has seen increased pay freezes, cuts and caps since 2010. For example, the teaching profession has seen their pay frozen or capped at a 1% increase since 2010. The state’s argument for freezing and capping pay is to reduce the public deficit caused by the recession. However there are crucial implications here for the public sector labour force, particularly women since they represent the majority of the workforce.
This is the same situation for doctors working within the NHS. The NHS was established in 1948, with a revolutionary vision of providing free healthcare at the point of delivery for everyone. With an ageing and growing population it now requires more funding than ever before. However, it is currently operating under a constrained budget, which the state argues is due to the financial crisis in 2008. NHS funding is so constrained that the British Red Cross publically called on the government to increase health and social care investment in January 2017 (British Red Cross, 2017). In addition there is also a shortage of doctors, particularly in general practice where the situation has been described as a “recruitment crisis” (Marchand and Peckham, 2017).

Independent analysis group, Monitor, alongside recommendations from the Department of Health, created a review publication titled: “The Five Year Forward View” in 2014, which again highlights the issues surrounding funding of the NHS. The main message of this publication is the need to reduce the expected £30 billion a year deficit the NHS will face if the NHS carries on operating the way it currently is with no annual changes to efficiencies and no flat real terms funding before 2020-1. The review argues this will only occur if the NHS is to improve efficiencies since additional funding is limited and public spending is working to a constrained budget:

“Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century” (Five Year Forward View, 2014, page 7).

One page of the 30-page report is dedicated to how NHS staff will shape and contribute towards the Five Year Forward View. In terms of doctors, most attention was placed onto postgraduate training, with an aim to increase the breadth of trainees’ training rather than trainees specialising too early. The state’s vision is for doctors to be able to work on different wards to gain the sufficient scope of medical knowledge required. It could be argued that this change to training is in fact due to the health service being stretched and under-funded, as having more generalist doctors means gaps in rotas on different wards can be filled.
In addition to the “Five Year Forward View”, the Conservative party also set out a plan for a “seven-day NHS”. The “seven-day NHS” plans stemmed from statistics utilised by the state, which claimed patient deaths were more common at the weekend. The state, fronted at the time by Health Secretary Jeremy Hunt, argued that this was because staffing levels were lower at weekends - a comment which sparked a huge outcry from doctors across the country, with hundreds of doctors joining the Twitter campaign ‘I’m in work Jeremy’ on social media. The state claimed the “seven-day NHS” is an initiative to ensure that “hospitals are properly staffed, so that the quality of care is the same every day of the week.” (Conservative Party Manifesto, 2015, page 38).

The initiative also claimed that patients would be able to see a GP seven days a week from 8am-8pm by 2020. However, rather than achieving this through hiring more staff, the state proposed that junior doctors’, including specialty trainees’, terms and conditions of employment were to be changed. This proposal could also be interpreted as an attempt to cut specialty trainees’ pay to further reduce the country’s economic deficit, even though it was presented as an initiative to improve efficiencies, save more patient lives and achieve consistent staffing levels across every day of the week.

Research by Meacock et al (2017) provides support for this view, since they found the state’s statistics on increased patient deaths at the weekend were extremely flawed because the state’s statistics actually revealed that those patients who were admitted to hospital at the weekend were more likely to die – not necessarily that they died because of the lack of care on admission at the weekend. The changes to the junior doctors’ contract are a fundamental contextual issue of this research. Therefore, longitudinal documentary analysis of the events leading up to the current imposed junior doctors’ contract is included within the empirical chapter concerning the employment experiences of specialty trainees (chapter six).

It should also be noted here that consultants’ employment contracts have also been reviewed by the DDRB and proposed changes have been discussed since September 2013. However, at the time of writing, no changes have yet been finalised. Despite no changes yet to consultant employment contracts, there are the early signs of the state’s intentions regarding consultants’ pay. The most recent annual DDRB recommendations in July 2018 suggested all doctors should receive a pay increment of
2% in October 2018, and consultants’ CEAs should also increase by 2% to match. However the state has ignored this and raised consultants’ pay by 1.5% and frozen CEA payment amounts. In addition, the state has decided not to backdate pay increments to April 2018 as they usually would. The BMA Chair of Council, Chaand Nagpal, wrote an open letter to the Department of Health to argue that doctors’ pay, including consultants, is continuing to fall behind the rate of inflation.

**CONCLUSION**

The purpose of this chapter was to outline the unique context of the medical profession in England and to identify areas of doctors’ employment that could potentially have gendered implications. There is a need to explore the actions of the state as the employer and the tensions caused by the contradictions of the ‘model employer’ image and its obligations under the equality duty and cuts to public spending during a time of economic austerity. It appears that the state plays a key role in shaping the employment of doctors in three main areas – pay, work life balance and the profession’s status. In addition, the state’s actions of degrading junior doctors’ pay and work life balance, through changes to their employment contracts, is happening at the same time as the feminisation of this level of the medical profession’s hierarchy. Similarly, it also appears that policy towards consultant’s pay is heading in the same direction.

The state has an influential role in the employment relationships of doctors from determining pay, funding the NHS and controlling NHS staffing levels. It is well documented that the NHS is clearly under a lot of pressure, both in terms of staffing levels and resources, so research questions concerning work intensity, working time and work life balance are essential, particularly since the workforce is feminising and women often wish to work flexible hours for childcare reasons. Likewise there are also issues around reductions to pay, especially for specialty trainees, as the junior doctors’ contract dispute was at its height during the period of data collection for this research. Also, in terms of devaluation, is there evidence that the state has chosen to target junior doctors’ contract because they represent the majority of women in the medical
profession, and how does that square with its apparent obligations to promote gender equality under the Public Sector Equality Duty?

As well as the state’s role as the employer, there are also other potentially gendered areas of doctors’ employment raised in this chapter to explore further during data collection. For example, does the organisation of specialty training programmes or differences in working time arrangements and obligations by specialty create gendered decision-making? This chapter and the literature review (chapter two) have both established a basis for the research questions and methodology, which are explained in the next chapter (chapter four).
CHAPTER FOUR
RESEARCH METHODOLOGY

INTRODUCTION
This chapter firstly aims to identify relevant research questions based on the literature review chapter and context of the medical profession in England. Following this, the justification of the research methodology used to address these questions is presented. To establish the most appropriate methodology, the researcher has considered Saunders et al (2015) ‘research onion’ framework (Figure 5) that highlights the multiple layers of research design, including the research philosophy; the research’s approach to theory development; methodological choice; research strategies; research time horizon and the techniques used for data collection and analysis. Each of these ‘layers’, relating to this research’s methodology, is described throughout this chapter.

Figure 5: ‘Research Onion’ (Saunders et al, 2015)
RESEARCH AIM AND QUESTIONS

This research aims to understand changes in the employment and careers of doctors and their relationship, if any, to the feminisation of the medical profession. Based on a review of the literature, four research questions were formulated. The first question stems from the literature concerning gender segregation, and why women tend to work in lower paid and lower status areas of occupations and professions (Reskin and Roos, 1990; Crompton and Sanderson, 1990). Looking more specifically at gender segregation within the medical profession, NHS Digital (2014) statistics show that men and women tend to work in different medical specialties, and female doctors are entering certain medical specialties at a greater rate than others. Therefore the first research questions aims to address these issues through the following question:

Research question one: how is gender segregation being produced in the medical profession, and what are the key factors in shaping this gender segregation?

Next, the literature also shows that once a profession becomes feminised, the profession may subsequently become devalued in terms of status, pay and job security - also known as the theory of devaluation (England, 1992; Kilbourne, 1994; Magnusson, 2009). This leads to the second research question to establish whether there is evidence of the medical profession becoming devalued since more women have entered in recent years:

Research question two: Has the feminisation of the medical profession led to the devaluation of the profession, and/or areas of the profession, in terms of professional status, pay and job security?

The literature review also shows that working time is a key aspect of women entering professions, mainly because women are more likely to seek a work life balance due to childcare responsibilities (Crompton, 2015). More generally, working time is changing towards a results-based model (Rubery et al, 2005a) where working time is no longer defined but depends on the time needed to complete the tasks or responsibilities in the job. At the same time, there has also been an increased need for attention to work
life balance due to the move towards more dual earner households, yet work life balance practices may be often at the benefit to the employer (Fleetwood, 2007; Özbilgin et al, 2011). In addition, recent research shows that fathers are increasingly seeking a better WLB (Gatrell et al, 2014). Working time in professions consists of long, scheduled paid working hours, alongside additional unpaid hours (TUC, 2017). Therefore, part-time working hours in professions often result in a lack of promotion opportunities (Higgins et al, 2000), difficulties accessing training (Arulampalam and Booth, 1997) and also lower job security (Conley, 2002). Since the medical profession is well known for its long working hours culture, the researcher was interested to explore how more women entering the profession may influence changes to working time in medicine, and how doctors (male and female) would experience working time at various stages of their careers. Therefore leading to the third research question:

**Research question three:** How has working time shaped the employment experiences of doctors, within the context of a feminising workforce, and to what extent has a feminising workforce shaped attitudes, and responses, towards working time arrangements within the medical profession?

Finally, the literature review then looks at how the involvement of the state, not only as the employer but also in its other multiple roles (Hyman, 2008), may impact on the employment experiences of doctors. Research has shown that the state has conflicting roles of being a model employer, whilst also adhering to strict budgets (Coffey and Thornley, 2009; Hyman, 2008), that often leads to the downgrading of public sector jobs, many of which are held by women (Conley and Jenkins, 2011). In addition, the state also has a public sector equality duty, enforced by the Equality Act, 2010. Thus raising the fourth research question:

**Research question four:** What are the roles of the state, and other institutions with influence over the employment relationship, in shaping the employment experiences of doctors within a feminising workforce?
PHILOSOPHICAL AND METHODOLOGICAL ISSUES

The researcher’s broad philosophical approach to this research, as highlighted in Figure 5, was ‘interpretivism’, which “emphasises that humans are different from physical phenomena because they create meanings” (Saunders, 2016, page 140) through gaining a richer understanding of a context by analysing different perspectives. More specifically, within the interpretivist philosophy, the researcher took a “contextual constructivist” (Madill et al, 2000) standpoint, which is defined by an assumption “that there are always multiple interpretations to be made of any phenomenon, which depend upon the position of the researcher and the context of the research” (King, 2004, page 256). Moreover, the researcher recognised that her personal beliefs, culture and perceptions could shape the way the research was analysed, interpreted and written. This philosophical standpoint also explains the reasoning behind the decision to consider the perspectives of participants of varying roles and seniorities, from doctors of different seniorities and specialisms, to officials of professional associations, since it is believed that the ways the key actors have interpreted and experienced feminisation may also differ.

As mentioned in the literature review, over the last thirty years research strongly suggests that gender should not be studied in isolation. To address this, studies started recognising other aspects of identity (such as ethnicity and age), and more recently looked at the implications of intersections between the different categorisations of identity, conceptualised as ‘intersectionality’ (Crenshaw, 1989). As a more recent development, many questions remain as to the most appropriate way to study intersectionality. On one side of the debate are writers who argue that intersectionality is the simultaneous intersecting of social inequalities and exclusions between multiple social categories such as gender and race (Hancock, 2007; MacDonald and Merrill, 2009). They add that it is the processes, patterns and power struggles produced by these intersections that researchers should be interested in, not merely the identification of patterns amongst certain categories that consequently treats categories as independent and separate entities. Therefore, if one was to take this viewpoint of intersectionality, there is the need for methodologies that advocate delving further into the experiences and processes of those who lie at the points of
particular intersections of interest. However, research that succeeds in analysing a number of social inequalities simultaneously in this way is rare (Acker, 2012), most likely because of the complexity involved in using intersectionality as a methodological tool and the vast amount of participants required to achieve truly intersectional research (Woodhams and Lupton, 2014).

Although some (such as Hancock, 2007) have strong views about what constitutes intersectional research, studies that acknowledge intersections of social inequality or demographic characteristics should not be dismissed as producing any lesser valuable knowledge. McBride et al (2015) refers to these studies that take into account the premise of intersectionality as being “intersectionally sensitive”. Since this research was not specifically focused on a group at a particular intersection (McCall, 2005; Healy et al, 2011; Oikelome and Healy, 2013), this research aimed to be “intersectionally sensitive” (McBride et al, 2015) whereby it is recognised that the experiences of all men and all women will not necessarily be the same. For example, the literature review highlights issues surrounding IMGs working in certain, often lower status and lower paid medical specialties (Fazel and Ebmeier, 2009), thus showing the intersections of ethnicity and nationality are also important to be considered alongside gender.

RESEARCH DESIGN
Looking at the next layer of Saunders et al’s (2015) research onion (Figure 5), the approach to theory development was inductive. Inductive research involves a “process that searches for patterns to generate theory…while the deductive approach is hypothesis testing” (Thyer, 2010, page 33). The NHS is an organisation where: “a complex pattern of organisational, work-group, professional and interpersonal loyalties exist” (King, 2004, page 21). Therefore the research consisted of three phases that represent the key stages of the medical career trajectory of doctors, to encapsulate the views and experiences of various actors at three key points of the typical doctor career trajectory, which are summarised in Figure 6 (page 89). This approach to the research design also aligns with the researcher’s interpretivist philosophical approach since a large-scale phenomenon, such as the feminisation of an
established male-dominated profession, from the viewpoint of a single group or case study would not provide rich, in-depth data (Chmillar, 2010).

However, as highlighted in the previous context chapter, each medical specialty is extremely complex and has its own unique characteristics. Consequently the researcher felt only three contrasting medical specialties should be explored for this in-depth piece of exploratory research. The three medical specialties chosen were anaesthetics, general practice and paediatrics. The researcher chose anaesthetics because of its high proportion of men at consultant level and high numbers of women entering the specialty at specialty trainee level. The researcher had also found prior to data collection that anaesthetics was more openly encouraging of LTFT training compared to other medical specialties on its NHS application webpage. In addition, anaesthetists work closely day-to-day with surgeons, a specialty dominated by men, and characterised as ‘macho’ and total dedication to the profession (Ryan, 2012), so the researcher was also interested whether this would play a role in the employment experiences and career choices, particularly of female anaesthetists. General practice was chosen, as it is the only non-hospital based medical specialty and GP Partners effectively run GP practices as small businesses. In addition, the number of men and women specialising in general practice were almost equal but many more men were in GP Partnership roles. The researcher was interested to discover why this is the case. Finally, paediatrics was chosen, as it is a long-standing female dominated specialty based within a hospital. Although the majority of consultants within the specialty are men, overall paediatrics is currently the most female-dominated medical specialty in the NHS.

Phase one focused on exploring the complexities of medical specialty choices, particularly looking at why women and men enter certain medical specialties, and whether location of primary medical degree (thus the intersection of ethnicity/nationality/gender) may also have an impact on medical specialty choice. This phase involved two points of data collection. First, a ten-question questionnaire (see appendix 6) was sent via email to specialty trainees from anaesthetics, general practice and paediatrics that asked about their career choices and decision-making.
Second, if the participant of the questionnaire gave consent, they were also interviewed for approximately one hour in order for the research to gain more depth from the information provided in the questionnaire regarding their reasons for medical specialty choice.

Phase two explored the next stage of the doctors’ careers – specialty training - where the day-to-day employment experiences of doctors whilst they are training within their chosen specialty were addressed. This phase was informed by the interviews with the same specialty trainees from anaesthetics, general practice and paediatrics that had completed the survey in phase one. It was deemed necessary to interview doctors at the earlier stages of their careers, as they are most likely a part of the recent female-dominated cohort of medical students. Also, because Training Programme Directors (TPD) at Health Education take responsibility of HR and medical workforce management issues concerning specialty trainees in this region, these individuals were also interviewed may be responding to and experiencing feminisation differently to consultants who may not have as much direct involvement with the working lives of specialty trainees. Furthermore, interviews with BMA and Royal College officials also informed this findings chapter.

Finally, phase three involved interviews with consultants, salaried GPs, GP Partners, a practice manager, and BMA and Royal College officials. The role of the state, and other actors with influence over the employment relationship, has in shaping the employment experiences of consultants and GPs within a feminising profession was considered. Interviewing consultants, salaried GPs and GP Partners for their views also helped capture within this research the attitudes and experiences of those who have witnessed and experienced the change towards feminisation as most would have entered the medical profession prior to the increase of female doctors. Another reason is that there is evidence that doctors in senior positions use nostalgia to impose their seniority on doctors in less senior positions (Tsouroufli et al, 2011). Also, GP Partners may have different experiences compared to consultants in the hospital setting since General Practice is operated as a small business and GP Partners are self-employed.
Overall, the research followed a simple mixed methods approach (see Figure 5) that considered a variety of different perspectives; qualitative and quantitative methods; and the choice of method was determined by the research questions rather than those that are seen as “intrinsically good” (Denscombe, 2014, page 147). The main research strategy was semi-structured interviewing in order to encourage responses of a narrative nature so rich qualitative stories and experiences were retold. To gain these narrative accounts, open questions were asked so participants could “introduce subjects of major importance to them” (Musson, 2004, p.37). An example of this style of question was “what attracted you to a career in [medical specialty]?” The questionnaire also provided rich qualitative data, but also allowed for a breadth of data, as more people were able to participate.

The majority of the data collection took place at a cross-sectional time horizon between February 2016 and September 2016. However one interview with a BMA official was conducted in December 2017, in order to explore the impact of the imposed junior doctors’ contracts.

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10 See Appendix 2 for interview schedules.
DOCUMENTARY ANALYSIS

During the time of data collection there were proposed changes to the junior doctors’ contract, as described earlier in the context chapter. Therefore the researcher also conducted documentary analysis on a range of documentation to capture the events of the contractual dispute that were unfolding. In addition, the research also analysed government reports of the allocation of Clinical Excellence Awards, to distinguish whether there were any differences based on gender and the likelihood of receiving an award. The researcher conducted targeted sampling of documents to ensure the relevance to the context at the time of data collection, which is common within research that takes a constructivsit philosophical approach (Linders, 2008). The following documents were analysed:

- Government reports
- DDRB reports
• Equality Impact Assessments
• Newspaper articles
• Clinical Excellence Award allocation data

To ensure that the appropriate documents were selected, the researcher used Scott’s (1990) four notions of authenticity; credibility; representativeness and meaning. Authenticity ensures that the authorship of documents is reliable, credibility ensures the accuracy of the content of the document, representativeness is to look at the availability of the document, and finally the meaning of the document is established from the interpretations of the researcher. The researcher interpreted the documents using textual analysis by “deriving an understanding from the qualitative significance of words, terms and images” (Fitzgerald, 2012, p. 302). The researcher was also aware of the potential bias of the documents analysed as they may have been constructed in a certain way that presents the content in a certain light and/or what the author of the document wishes to be in the public domain (Linders, 2008; Fitzgerald, 2012). For example, equality impact assessments may be presented in a way that downplays certain issues; and/or the political bias of certain newspapers may also affect how information is presented.

SAMPLING METHOD

Due to a wide range of different participants, the sampling method varied according to the participant’s employer, setting or group. For the first phase, regarding specialty trainees’ career choices, the sampling method was purposive since only specialty trainees from anaesthetics, paediatrics and general practice within the same HEE region were interviewed or surveyed. Similarly for phases two and three of this research - Royal College Officials and BMA representatives; consultants, salaried GPs and GP Partners were purposively sampled depending on their specialty area, job title and primary place of work. Purposive sampling is required for the majority of this research to ensure that those involved in the study are relevant to the research questions (Bryman, 2012, p.418). In some instances, snowball sampling also occurred as participants introduced the researcher to other relevant participants. This was felt by the researcher to be beneficial because it allowed for a larger number of responses,
which equates to a greater understanding of the research area.

The self-selection aspect of the survey and the snowballing sampling for some interviews resulted in the vast majority of informants being either White British male or female. A sample consisting of a more comprehensive group of respondents with intersecting social characteristics was not possible. As no group is homogeneous in their interpretations or experience, attention is given throughout to those experiences that differ from those expressed by the majority of respondents and attention paid to what might explain differences within and between groups.

PARTICIPANTS
A total of 226 specialty trainees from anaesthetics, general practice and paediatrics participated in the phase one survey, the details of whom can be seen in Appendix 3. From the survey participants thirty specialty trainees also participated in an interview with the researcher, as listed below. A total of 30 specialty trainees from the phase one survey were also interviewed, and are listed below in Table 3. The research participants also included six consultants from anaesthetics and paediatrics, two GP Partners, two salaried GPs, one Practice Manager, three TPDs, and six BMA and respective Royal College Officials (the details of whom can be seen in Tables 4 to 7 below).
Table 3: Specialty trainee interview participants

<table>
<thead>
<tr>
<th>Interview Number</th>
<th>Specialty</th>
<th>Gender</th>
<th>Ethnicity (Self-identification in survey)</th>
<th>Stage in training</th>
<th>Interview Type</th>
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<tbody>
<tr>
<td>1</td>
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<td>ST5</td>
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<td>British Filipino</td>
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<td>CT1</td>
<td>Telephone</td>
</tr>
<tr>
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<td>Final Year</td>
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<tr>
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<td>White Thai</td>
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</tr>
<tr>
<td>8</td>
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<td>ST1</td>
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<td>9</td>
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<td>Mixed White / Middle Eastern</td>
<td>CT1</td>
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</tr>
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<td>ST6</td>
<td>Face to face</td>
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</table>
### Specialty and gender breakdown of interviewees

14 Paediatricians – 4 male / 10 female  
9 Anaesthetists – 5 male / 4 female  
7 GPs – 3 male / 4 female

### Table 4: NHS Hospital Trust case study consultant participants

<table>
<thead>
<tr>
<th>Interview</th>
<th>Specialty</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Job Role</th>
<th>Interview Type</th>
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</table>
### Table 5: GP Practice-based participants

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<tr>
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<td>41</td>
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### Table 6: Professional Association participants

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<tr>
<th>Interview</th>
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<th>Gender</th>
<th>Ethnicity</th>
<th>Association</th>
<th>Interview Type</th>
</tr>
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<td>BMA</td>
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<td>British Indian</td>
<td>BMA</td>
<td>Face to face</td>
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<tr>
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<td>BMA</td>
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Table 7: HEE region Training Programme Directors participants

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<td>General Practice TPD</td>
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GAINING ACCESS

Gaining access to a range of NHS organisations and other institutions involved in the medical employment relationship was key for meaningful data to be produced. In this research, access needed to be granted by the HEE region, the BMA, the RCA, the RCPCH, RCGP, NHS Trust Foundation Hospitals and GP Practices. Gaining research access to the NHS is well known to be a lengthy and elaborate process, consisting of numerous procedures, which are discussed in more detail later in this section. This is mainly due to the possibility that healthcare research may involve patients, and the NHS is obliged to demonstrate a duty of care towards them. Even though this research does not involve patients, some interviews were conducted on-site at NHS organisations. Therefore formal access procedures were followed. It should also be noted that, although Health Education England is separate from NHS Local Employers, NHS documentation was still required to gain access.

Since this research consists of three phases, in multiple NHS and non-NHS sites, the researcher recognised that gaining access would not be a straightforward task due to the numerous layers of gatekeepers that needed to be approached. Gatekeepers essentially have control over the researcher in terms of who will participate and whether the research can ultimately be conducted. Although the NHS has put in measures to streamline the access process, such as the completion of a single research
application form to gain research access across the NHS, the researcher was still required to approach each NHS site separately in order to gain permission to physically conduct research on NHS premises. NHS ethics has also put measures in place to ease the access process for social science researchers interested in studying NHS employees by stating that research of this nature does not require full Health Research Authority (HRA) approval that is required for research involving patients. This means access is granted on a site-by-site basis. This was beneficial to the researcher, because access was not granted at one NHS Hospital that was approached. Therefore an alternate NHS site was used.

Regarding access to senior officials of the British Medical Association and the relevant Royal Colleges, potential participants were approached via email depending on their occupational responsibilities. The researcher also used the less formal sampling method of snowballing, whereby participants were accessed through networking at events. When approaching gatekeepers of organisations to gain access for research, evidence of ethical approval from the research sponsor and the adherence to ethics guidelines were often requested. This is certainly the norm in the NHS so the researcher had to stringently assess the ethical issues that may arise in this research.

**ETHICAL ISSUES**

Although ‘ethics’ can have various definitions, it is broadly seen as “a set of principles that embody what is good or wrong, or allow us to identify what is bad or wrong” (Hammersley and Traianou, 2012, p. 16). Since the late 1980s, ethics has evolved from an issue predominantly concerned with science experiments and has become increasingly important within management and social science research (Bell and Bryman, 2007; Hammersley and Trainou, 2012; Birch et al, 2002). Ethical issues are most commonly considered at the beginning of the research process via the creation of consent forms, participant information sheets and, in some cases, seeking formal ethical approval from the research’ sponsor. However, the case has been made that the assessment of ethical issues should not be confined to the start of the research and should be continually reassessed throughout the research process (Birch et al, 2002). The researcher achieved this through reflecting on the research process
through the completion of a research diary. Although these steps were time consuming, the researcher felt it was important that ethical issues were revisited throughout the research process, not only to ensure the safety of their participants but also to the researcher.

In social science research, the likelihood of causing the participant harm is low (Bell and Bryman, 2007) and it can be the case that participants benefit from telling the researcher about their experiences (Sikes, 2012). However ethics for this research required careful analysis as any harm, wrongdoing or risk towards the participant could have detrimental effects if not considered beforehand since the research is essentially bound to the NHS, which is renowned for its strict ethics procedures. Therefore, prior to the interviews the participants were informed of the nature of the research and asked to sign a consent form that highlighted what the research entailed, that they would be audio recorded and information about where the raw data would be published and stored.

Due to the research topic, there was the possibility that sensitive issues may arise. For example, the participant may feel their gender and/or ethnicity has had a negative impact on their career. The researcher prepared a distress policy for the unlikely event that a participant felt uncomfortable at all during the interview, which gave the participant the option to cease the interview and withdraw from the research process if they wanted to. The researcher was also prepared to provide guidance on post-interview support to ensure the participants’ wellbeing was considered at every stage of the research process. However participant guidance, and the distress policy, were not required.

When researchers deal with the issues of confidentiality and anonymity, the distinctions between the two can often become blurred (Bell and Bryman, 2007). Confidentiality refers to the protection of the raw data that the participants provide, whereas anonymity refers to the protection of the participant’s identity (Bell and Bryman, 2007). To ensure confidentiality, the recorded data was kept on the researcher’s laptop and university computer only, and not transferred to other
computers, laptops or electronic devices. All files and folders on the researcher’s laptop and university computer containing participants’ data were encrypted in order for them to remain completely confidential. The audio recordings of interviews were also deleted once they were transcribed.

When looking at anonymity, it is important to note that the term applies to the identity of both the organisations and the participants. It is vital for researchers to protect the identity of participants to ensure they are not victimised for the information they have shared (Bell and Bryman, 2007). Although there is evidence of participants requesting to be identified so their voices are heard (Grinyer, 2002), in this research, participants’ identities have been protected through the use of pseudonyms. Due to the intersectionally sensitive nature of the research, and so comparisons can be made, the researcher included: the participant’s job role, gender, location of medical training and ethnicity in the results. However, for the participant to not be identified, the location of the HEE region, NHS Trust or GP Practice was anonymised. Therefore, without geographical information, it would be extremely difficult to pinpoint the identity of a participant from such a broad description. Nevertheless the organisational name (NHS) will be provided as it helps the reader to understand the context of the research without disclosing a specific location. It is also clear to all that a study of the medical profession in the UK would involve those working for the NHS.

Since the Economic and Social Research Council (ESRC) funded this research it is a requirement that the anonymised raw data is deposited in the UK Data Service repository for future research. However, the researcher will only deposit this raw data for participants who authorised this on the consent form. All participants agreed to their anonymised interview data being shared.

ETHICAL CONCLUSIONS
Since all ethical issues were considered, this research was granted ethical approval by the University of Manchester Ethics Committee (University Reference Number: 15517). Some argue the ‘bureaucratisation’ of research ethics and stringent procedures can lead to a less flexible and more closed research strategy (Webster et al, 2004; Wiles et al, 2005; Sikes, 2012). Others argue that gaining ethical approval can give the research
more credibility (Hallowell et al, 2005). In this research ethical approval provided the research with more credibility, as the NHS ethics procedure is well known to be thorough.

It should also be noted here that much of NHS research governance, understandably, focuses on medical research, such as clinical trials. This causes difficulties for social science research, such as this research, as it is not crystal clear for the researcher, ethics committees or the gatekeepers what guidelines should be followed and how strictly. The researcher has found that the lack of coherence caused gaining ethical approval to take longer than anticipated, and caused some NHS hospitals to not grant access.

**DATA ANALYSIS**

Thematic analysis of the qualitative data was deemed most appropriate, as it is more conducive to the contextual constructivist philosophical approach taken in this research (King, 2004, p. 257). The themes were established by condensing the large volume of rich data by the identification of recurring patterns. Specialty trainees and those in their ‘destination jobs’ are analysed separately so that cross-case comparisons can be made.

To conduct thematic analysis, firstly the interviews were transcribed and then codes were assigned to “identify a feature of the data...that appears interesting to the analyst” (Braun and Clarke, 2006, p. 88). These codes were then combined to produce overarching themes. Braun and Clarke (2006, p. 87) suggest that there are six steps that are to be implemented when conducting thematic analysis, these are:

1. Familiarising yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report
As this research takes a contextual constructivist approach, the reflexivity of the researcher and familiarisation with the data is key to ensure the data is not fragmented and removed out of context during thematic analysis.

The researcher chose to use descriptive statistics to highlight general trends across the survey data collected due to the relatively small sample from each medical specialty, which made it problematic to conduct statistical inference. Therefore the researcher does not suggest that statistical inferences can be made to the general population of specialty trainees. To conduct descriptive statistical analysis, all survey data was transferred to Microsoft Excel, where the researcher analysed any general trends in the data based on gender, ethnicity or location of medical training.

**AUTHOR VOICE**

In the writing up stage of research, particularly in qualitative research, it is important that the participants’ voices are ‘heard’ accurately and honestly, since there is the danger that participants’ voices can become lost once interviews are transcribed and coded. Also, on an ethical note, the researcher has a duty to the participants to write and portray the findings accurately and honestly (Sikes, 2012). May and Patillo-McCoy (2000) found two researchers interpreted the same situation very differently, so the researcher has taken the appropriate measures to ensure that participant’s responses were accurately interpreted and presented.

To ensure that the participants’ voices are heard, it is often the assumption that the researcher must not become too submerged, and instead try to distance themselves from the data in order to stay objective and ‘scientific’. Thus it is often the assumption that the researcher’s personal beliefs, culture, professional background, gender and epistemological stance should not impact too much on the way the research is written. However, upon reflection, these influences are inevitable since the researcher shapes every aspect of the research from the original research idea to the literature reviewed. An example of how this situation can occur is documented in Li and Seale’s (2008) research regarding their personal experiences of the PhD process from the viewpoints of the student and the supervisor. In the writing up and data analysis phases, the
supervisor noticed that because the student was previously employed as a nurse and that the participants were nurses, that she appeared to take what the nurses said at face value and support them. However the supervisor felt that this was not a reflection of the social sciences, so advised the student to use the techniques of ‘bracketing’ (whereby the participants’ responses are not taken at face value and are further analysed to find whether the participant is presenting themselves in the way they want to be perceived) and ‘distancing’ (whereby the student takes a more critical stance rather than implicitly supporting the participants she was interviewing) when writing up her research. These techniques were implemented by the researcher during data collection and analysis for this thesis, and proved useful when writing up the findings, particularly as a feminist researcher who may be intrinsically inclined to champion the views of the female participants. However it should be noted, “gender is central to the way we perceive and structure the world and events in which we participate.” (Jarviluoma et al, 2003, page. 1). Also, there are claims that qualitative methods associated with feminist research such as this, can often be “dismissed as biased, activist or substantively marginal” by advocates of the quantitative approach (Harnois, 2012). Therefore, the researcher aimed to achieve a balance between their own involvement and distancing during data collection. The researcher also chose to include some lengthier interview quotes within the findings chapters, drawing on Geertz’s (1973) and Denzin’s (2001) ideas of “thick description”, to preserve the amount of text necessary to fully illustrate the complex contextual issues and the interlinking nature of the main themes that emerge from this research.

RESEARCH LIMITATIONS

One of the main research limitations was gaining access to a higher number of participants who held senior positions as consultants, GPs and senior officials. Therefore the breadth of data from this demographic is not as great as the researcher had planned. However, through secondary analysis of publically available data, the researcher could explore the employment issues raised in the interviews to supplement the data, such as the analysis of the allocation of Clinical Excellence Awards for consultants. It may also be a limitation that intersectional analysis of the data was not possible, which means there may be an experience that this research is
not capturing. For example, recent NHS Digital (2018) data shows 55.5% of specialty trainees in NHS England are White, whereas 70% of participants in this research identified themselves as White British. Even though White specialty trainees are the majority (albeit small), White British specialty trainees are still overrepresented in the research sample. However the specialty trainee interview sample does appear to be representative in terms of gender and medical specialty across all three specialties. For example, 71% of the paediatrics interview sample was female, which is in line with 73% of the overall population of paediatrics trainees in England whom are female.

The feminist nature of this research could be seen as a limitation in the sense that the researcher’s personal ideologies and values may impact on her view of reality (Grbich, 2013). Although this could be argued to be the case for all pieces of research, the researcher has recognised that due to the feminist nature and her own views, that the data collection and analysis was interpreted using the participants’ voices. As mentioned, the research took place at a cross sectional time horizon. Due to the distinct context of the junior doctors’ contract dispute during data collection, it may be that the employment experiences doctors reported may be perceived differently compared to another timeframe, for example compared to interviews now the final contract has been imposed.

CONCLUSION
The research design was guided by both the exploratory nature of the research and the rigid ethical framework and access permissions the research was required to adhere to. Although an additional ethnographic phase to the research could have added more of a descriptive element – given the relatively short time frame and difficulties in gaining ethical approval for the methodology implemented, this was not felt to be feasible. These circumstances support Truman’s (2003) argument that the bureaucratisation of ethics has imposed constraints on the actual conduct of the research. Despite this, the researcher’s chosen methods of interviews and questionnaires ensured that the research questions could be aptly addressed and explored, whilst maintaining the credibility of the research since ethical approval was successfully granted. The combination of rich, qualitative data contextualised by
selective use of quantitative data provided a basis for addressing the gaps in the literature concerning working time in professions, feminisation, and the state’s role as the employer within the complex context of the medical profession.
CHAPTER FIVE
DETERMINANTS OF MEDICAL SPECIALTY CHOICES

INTRODUCTION

Statistics produced by NHS Digital (2018a) show that certain medical specialties are feminising at a greater rate than others, as discussed in the literature review. However, research in this area tends to focus mainly on internalised gender roles dictating decision-making when explaining why men and women choose certain medical specialties. For example, that differences in male and female personalities shape specialty choice (Stilwell et al, 2000; Buddeberg-Fischer et al, 2003; Kiker and Zeh, 1998) and/or that women place more importance on achieving a good work life balance compared to men as they hold the majority of childcare responsibilities (Sanfey et al, 2006; Johnson et al, 1992; Al-Nuaimi et al, 2008). Very little research has been conducted within the UK context regarding gendered medical specialty choices that considers the potential impact of the state as the employer, and other institutions with influence over the employment relationship. For example by shaping the training system, job security, career progression prospects and working hours. It may also be expected that this unique set of complex institutions involved with doctors’ employment relationships, as highlighted in the context chapter (Chapter Three), combined with public sector economic austerity measures, and the increase in female doctors entering the medical workforce may also contribute to the gender segregation seen within medicine.

This chapter presents the findings related mainly to addressing the factors shaping the gender segregation of medical specialties. The findings are informed by data collected through questionnaires and in-depth, semi-structured interviews with specialty trainees. The questionnaire focuses on reasons for medical specialty choice, and was completed by 226 specialty trainees from the same geographic region of HEE specialising in anaesthetics (n=69), general practice (n=81) and paediatrics (n=76), at various stages of their training programmes (see Appendix 7). Respondents of the survey were also given the opportunity to participate in an in-depth semi-structured
interview with the researcher. The interview data delves deeper into reasons for medical specialty choices and perceptions of different career paths, progression opportunities, and potential barriers to medical specialties. A total of thirty respondents from the survey also took part in an interview, the details of whom can be seen in Table 3 in the methodology chapter (chapter four). The findings from the survey and interview data are presented and analysed separately in this chapter, firstly looking at the data collected from the survey, followed by further in-depth analysis of the richer, qualitative data from the thirty interviews with specialty trainees. Thematic analysis has been conducted to analyse the qualitative data from the survey and interviews, whereby the large volume of rich data has been condensed through the identification of recurring patterns. Codes have then been assigned, and combined, to produce overarching themes.

The analysis is framed using the arguments from literature review including reasons for gender segregation, devaluation, working time, and how the state as the employer, alongside other institutions involved in the employment relationship, could have an influence on the employment experiences of doctors, particularly during a time of austerity. Using an inductive approach, the views and perceptions of specialty trainees are explored to see if links can be made to their career decisions and the actions of the state, and other institutions within the employment relationship. It should also be noted that the researcher has also considered the impact of other intersecting social characteristics, such as specialty trainees’ ethnicity and nationality because, as mentioned earlier in the literature review chapter, the location of primary medical degree (an intersection of ethnicity and nationality) has been found to have an impact on medical specialty choice (Oikelome and Healy, 2013; Fazel and Ebmeier, 2009). Consequently the aim is to gain an insight into what shapes certain medical specialties to become more feminised than others.
SECTION ONE: SURVEY DATA ANALYSIS

In this section, each of the three chosen medical specialties are explored in turn, to analyse reasons for medical specialty choices and whether a specialty trainee’s gender, ethnicity and/or location of medical degree may determine medical specialty choices and, if so, why? The specialty choice reason criteria included within the survey was influenced partly by Elston’s (2009) framework (see Figure 3, page 54). Elston’s (2009) research on male and female doctors’ medical specialty preferences in the UK found that four key factors explain the gendered differences in doctors’ specialty choices. She uses her findings to argue that women are more likely to choose medical specialties that are more people orientated; less technology focussed; and have scheduled working hours that can be easily planned. In contrast, Elston (2009) finds men are more likely to choose medical specialties that are more technology-orientated; less people-orientated and have more unpredictable working hours.

After stating their gender, self-identified ethnicity, location of medical degree and specialty choice, respondents were asked to state from the following reasons why they chose their medical specialty, with the option to add their own comments should their reason not feature on the list:

- High patient contact
- Low patient contact
- Hospital setting
- GP setting / clinic
- Flexible working hours / work life balance
- Shorter training length
- Availability of LTFT training
- Salary
- Likelihood of gaining a place on the programme
- Specialty culture
- Use of technology
- Potential colleagues
Questionnaire respondents were then asked whether their specialty choice was their first choice, to determine whether any other potential factors that influenced their decision-making. Following this, respondents were then asked whether they felt their gender had an impact on their specialty choice, and likewise whether they felt their ethnicity had an impact of their specialty choice. The survey data shows that there are differences between respondents’ reasons for medical specialty choices based on gender and, in one instance, location of medical degree study. These reasons gathered from the survey data are discussed separately in this chapter according to medical specialty, due to each medical specialty having its own unique characteristics, as highlighted in the context chapter (chapter three).

ANAESTHETICS – REASONS FOR SPECIALTY CHOICE

It can be seen that the majority of anaesthetics trainees chose the specialty for its hospital setting and the specialty’s culture (see Figure 7). From the survey data collected, male and female anaesthetics trainees identify differing factors for choosing anaesthetics in particular areas (see Figure 7). For example, although working in a hospital setting was very important for both male and female trainees when choosing anaesthetics, choices based on work life balance, availability of LTFT training and use of technology varied quite considerably between the male and female anaesthetics trainees surveyed. The availability of LTFT and achieving a work life balance is much more important to the female respondents, compared to the male respondents, with 41% of women compared to just 3% of men choosing anaesthetics due to the availability of LTFT training. One female respondent stated that the specialty is “very well set-up for LTFT training” (female anaesthetics trainee, survey response 9). Several respondents commented that this is the case because the nature of working time in anaesthetics lends itself well to working reduced hours. For example, a female anaesthetics trainee said:

“Able to focus on each patient completely without being pulled in other directions, you stay with one patient as long as they are anaesthetised - no question. No ward rounds. You go home when your job is complete (no other job completely done – there’s always more patients on your ward...yes, it is a specialty which lends itself very well to LTFT training as you don’t have on-going
Another, male, anaesthetics trainee survey respondent commented that the planning of the rotas in anaesthetics was also a determining factor in choosing the specialty as it allowed for longer periods of continuous time to be spent with family:

“Anaesthetics allows me a great deal of flexibility and due to intensity of work when I am on-call, I have more rest days during which I will have time to spend with my family (male anaesthetics trainee, survey response 156).

As well as the nature of the working time, the culture of anaesthetics was also seen as a specialty that is more accepting of work life balance and particularly working LTFT:

“the ease of access to LTFT in anaesthetics is something I enjoyed and I think it fits the specialty culture” (male anaesthetics trainee, survey respondent 165).

The survey data shows the culture of anaesthetics generally is one of the main draws for both the male and female anaesthetics trainees surveyed, with 87% of male trainees and 64% of female trainees stating this was one of their reasons for choosing the specialty. A number of survey respondents elaborated on their opinions of the culture of anaesthetics, describing it as ‘friendly’ and ‘supportive’. A male anaesthetist trainee commented that he felt the culture of anaesthetics has encouraged more women to enter the specialty:

“the resistance to change in hospital medicine working hours and often a longer training programme is a huge deterrent to more women in hospital medicine. Anaesthetics is one of a few specialties which has embraced change and is more forward-thinking; resultantly there are simply more women in anaesthesia. It then becomes a self-fulfilling prophecy as more women are present to ensure that change is made and sustained” (male anaesthetics trainee, survey response 200).

Views of the specialty culture in anaesthetics are explored later in this chapter using the qualitative interviews, since specialty culture was an important consideration for the majority of respondents when applying to specialise in anaesthetics.
The survey responses from anaesthetics trainees do not highlight any significant links between specialty choice, and ethnicity and/or location of primary medical degree. Only one survey respondent from anaesthetics commented that they felt their ethnicity determined their specialty choice, stating that he felt subconsciously his ethnicity had impacted on his medical specialty choice as “many middle / senior grade surgeons and anaesthetists are Asian” (male anaesthetics trainee, survey response 214). Although recent NHS Digital (2018c) data shows 27.3% of specialty trainees identify as Asian, there is no public data available to confirm the ethnic representativeness of specialty trainees in anaesthetics. Therefore it is not possible to indicate whether the sample is representative of the population of specialty trainee anaesthetists to determine the potential impact of ethnicity and/or location of primary medical degree.

Overall, contrary to Elston’s (2009) framework, which claims female doctors are less attracted to anaesthetics due to its “unpredictable” working hours, the survey data shows that 64% of female respondents chose anaesthetics due to the expected achievable work life balance, compared to 24% of male respondents. However, there is evidence of both men and women choosing the specialty for its controllable working hours and ability to work LTFT, which appears to be mainly due to the sessional nature of the work. Supporting Elston’s (2009) framework, the survey data shows male anaesthetics trainees are more likely to be attracted by the use of technology in anaesthetics compared to women, as seen in Figure 7, as almost 50% of male trainees feel the use of technology was an important factor when they chose to specialise in anaesthetics, compared to just 18% of female anaesthetics trainees surveyed.
Figure 7: Male and female comparison of medical specialty choices - anaesthetics
GENERAL PRACTICE – REASONS FOR SPECIALTY CHOICE

Figure 8 shows that both male and female GP trainee respondents place significant importance on achieving a work-life-balance when choosing general practice, with 96% of female trainees and 80% of male trainees stating this is the reason they chose general practice. However the availability of LTFT training was much more important for female trainees with 43% stating that it was an important factor when choosing general practice, compared to just 8% of male GP trainees surveyed. The qualitative survey comments showed that women were drawn to the specialty for childcare reasons, as general practice is perceived as a specialty that is compatible with having children as the specialty appears to accommodate part-time working and consequently an achievable work life balance:

“one of the reasons why I chose GP was so that I could start my own family and be able to work part-time. I feel that other specialties do not accommodate this in their training or once a consultant” (female GP trainee, survey response 111).

The perception that general practice allows for a better work life balance compared to hospital-based specialties appears to be because there were fewer unsocial hours to be worked during the night and weekends:

“As a woman I have to look after my kids and my home, have to take maternity leave, and these factors led me to choose GP training as there are no on calls and night shifts and I can balance my work and home better” (female GP trainee, survey response 101).

In addition, some of the female GP trainees commented on geographical stability being a draw for them, as trainees feel they are “more likely to gain a place in the geographical area [they] want to live” (female GP trainee, survey response 209) compared to hospital-based specialties. These choice factors for female trainees relating to the working time features of general practice and childcare responsibilities appear again in responses the survey question “do you feel your gender has had an impact on your specialty choice”?, since 55% of female GP trainee respondents, compared to just 8% of male GP trainees, stated ‘yes’ and the majority of female GP trainees added this was due to maternity and childcare reasons.
Due to the perceptions that a work life balance is more achievable in general practice compared to hospital medicine, the survey data also shows that general practice is more often a second choice of specialty for trainees, compared to trainees surveyed from anaesthetics and paediatrics. Almost 20% of general practice trainees stated that general practice was not their first choice, the vast majority of whom were women. From the responses given, female respondents stated this is due to the perception of achieving a better work life balance in general practice to look after their children since there is much less of a requirement to work during ‘unsocial’ hours compared to hospital-based medical specialties. For example a female GP trainee respondent said:

“[I] changed from oncology to GP to better combine work with role as primary care giver for kids. Felt [specialty training] years in hospital post coincided with time I wanted to focus more on family” (female GP trainee, survey response 145).

Similarly, another female GP trainee respondent commented that she felt she had to make more sacrifices to her family life whilst working in surgery so changed to general practice:

“I spent around 10 years training in Surgery, reaching ST7 before deciding to retrain as a GP. I had loved surgery prior to having children, but after having them realised I wasn’t prepared to make the required sacrifices to family life” (Female GP trainee, survey response 87).

The survey data from GP trainees also shows there is a link between gender and the country where the participant conducted their medical training. The survey data suggests that male GP trainees who completed their medicine degree outside of the UK are more likely to choose general practice based on the likelihood of gaining a place on the programme. Four out of six male, non-UK trained, GP trainee survey respondents stated they chose general practice because they perceived it to be easier to gain a place on the training programme. However only three out of eleven female general practice trainees who have trained outside the UK stated that the likelihood of gaining a place on the training programme contributed to their specialty choice of general practice. In addition, just two out of the nineteen male GP trainee survey
respondents who studied their medical degree in the UK stated less competition to be a factor when choosing general practice. The male GP trainees who stated the difficulties of gaining a training number on more competitive specialty training programmes, said the shorter training length of general practice allowed them to qualify quickly to progress their careers more quickly. For example, a male GP trainee who had studied for his medical degree outside of the UK said he was:

“unable to get training number in high demand specialty [cardiothoracic surgery]. Fed up of being dragged around country on different placements. Just want to buy a house, settle down and get on with my life! (male GP trainee, survey response 115).

This preliminary finding from the survey data raises a number of questions to be addressed in the interviews. Are IMGs unable to gain training places on more competitive specialty programmes because of their IMG status? Or perhaps IMGs feel they cannot apply for the more competitive training programmes in the UK, as they feel they are more likely to have their application rejected? These questions are explored further within the interviews to gain more in-depth information about why GP trainees, usually men, who have completed their medical degree outside of the UK, are opting for general practice as a second choice.

When comparing the survey data from the GP trainees with Elston’s (2009) framework (Figure 3, page 54) on which the survey was largely based, this survey data challenges the framework. For example, the male GP trainee respondents are more likely than the female GP trainees to choose general practice based on having more patient contact, and no men surveyed stated the use of technology as being a draw towards general practice. Overall, although men and women both rate work life balance highly as a motivator for choosing general practice, there appear to be gendered reasons for this with women stating working in GP is more compatible with looking after their children. This is illustrated by significantly more women than men stating the availability of LTFT was an important factor when they chose general practice.
Figure 8: Male and female comparison of medical specialty choices – general practice

- **Potential Colleagues**
- **Use of technology**
- **Specialty culture**
- **Likelihood of gaining a place on the training programme**
- **Salary**
- **Availability of LTFT training**
- **Shorter training length**
- **Flexible working hours / work life balance**
- **GP surgery / Clinic setting**
- **Hospital setting**
- **Low amount of patient contact**
- **High amount of patient contact**

**Factors influencing specialty choice**

- **Female**
- **Male**

**Percentage**

- 0 10 20 30 40 50 60 70 80 90 100
PAEDIATRICS – REASONS FOR SPECIALTY CHOICE

The vast majority of survey respondents specialising in paediatrics were female (92%) (see Figure 9). However, unlike general practice and anaesthetics, very few female trainees surveyed stated that work life balance was a reason for choosing to specialise in paediatrics. The survey responses appear to show that many female paediatric trainees did not consider work life balance issues, such as working nights and weekends, when choosing their specialty as it was prior to entering long-term relationships and thinking about starting a family:

“I did not give work/life balance or other considerations a thought at the time of choosing but now wish I had!” (female paediatrics trainee, survey response 20)

However almost 40% of female paediatric trainee survey respondents stated that the availability of LTFT training was an important factor to them. Again, the survey data shows that this percentage may be lower due to the stage of trainees’ lives when they choose their medical specialties:

“The availability of LTFT training was a consideration at the time I chose my specialty but much less so due to my age when I began paediatrics training - I was only 23 and imagined I would complete my training full time by my early 30s and only then have a family (not how it has worked out, in the end, as it happens!) So availability of LTFT training was only a minor consideration for me then really” (female paediatrics trainee, survey response 38).

Female paediatrics trainees who stated the availability of LTFT training was an important factor when choosing their specialty, said this perception of paediatrics stemmed mainly from witnessing senior female consultants as role models, whom “were able to succeed whilst having a family, and also being ‘normal!’” (female paediatrics trainee, survey response 54). A number of female paediatric trainee respondents said the strong presence of female role models in paediatrics was different to most other hospital specialties, also giving the impression that “LTFT training would be more accepted and less frowned upon” (female paediatrics trainee, survey response 35).
The survey data also shows that more women in paediatrics generally create a unique culture within hospital medicine, often described as ‘nicer’ and ‘friendlier’ than most other medical specialties. Again, the culture of paediatrics contributed towards female trainees feeling they could achieve a better work life balance within medicine:

“I feel that there is a very supportive culture regarding less than full time training & also people seem to generally be ‘nicer & more friendly’ i.e. other doctors, consultants, nurses & allied health professionals!” (female paediatrics trainee, survey response 44).

The few male paediatric trainee respondents all rated the specialty culture as their main reason for choosing to specialise in paediatrics. In addition, all of the men commented that they enjoyed working with children and dealing with a patient holistically, unlike other specialties that focus on certain areas of the body. Over a third (34%) of the female paediatrics trainees felt their gender had an impact on their specialty choice, due to their perceptions of women having “maternal instincts”, a “softer skill set” and also the predominance of female role models influencing their decision-making.

Overall the survey data provides evidence to contradict Elston’s (2009) framework which states women are attracted to paediatrics because it is more ‘plannable’ in terms of working time. From the survey data, paediatrics trainees are aware that work life balance is not good in paediatrics, the training length is long but paediatrics is still the most female-dominated specialty (NHS Digital, 2018a). The findings show that the presence of many senior female role models has been incredibly influential for women choosing paediatrics as a specialty choice. Perhaps because paediatrics has been female dominated for a longer period of time, it has established itself as being more ‘female-friendly’. Paediatrics is a long training programme (eight years), with many examinations and, long unsocial working hours. Therefore paediatrics seems to break the mould of what may be expected from a female-dominated medical specialty. These findings are looked into further during the interviews with paediatric specialty trainees.
Figure 9: Male and female comparison of medical specialty choices – paediatrics
COMMONALITIES AND DIFFERENCES IN MEDICAL SPECIALTY CHOICES FROM THE SURVEY DATA

From the survey results, the hospital setting appears to be a common important driver for trainees choosing the hospital-based specialties (paediatrics and anaesthetics). The hospital setting may be attractive to trainees due to the perceptions of teamwork, more colleagues from whom to seek guidance and support when handling acute medical issues. However, for general practice, the draw for trainees, both male and female, is much more towards achieving a work life balance. This is probably due to the fixed weekday, daytime shift patterns during training, unlike the working hours found in anaesthetics and paediatrics.

The survey data also shows evidence of gendered reasons for specialty choice across all three medical specialties, particularly in relation to working time issues. For example, the availability of LTFT training is much more important to female trainees when choosing their medical specialty across all three specialties. In addition, all three specialties were found to have the perception of welcoming and accepting LTFT training compared to other specialties, namely surgical specialties and A&E. However, the varying contexts of each medical specialty mean the views of there being good availability of LTFT training to be different for each medical specialty. For example, the nature of sessional shifts allows for LTFT to be easier to organise and achieve within anaesthetics; there appears to be an expectation within general practice that trainees choose the specialty to achieve a better work life balance so the availability of LTFT comes with that; and the senior female role models in paediatrics showing prospective trainees that job sharing is commonplace and accepted.

In contrast to anaesthetics and general practice, paediatrics trainees do not perceive paediatrics as a specialty that is conducive to achieving a better work life balance. Therefore, as mentioned, this confirms that the senior female role models play a key part in encouraging more women into the specialty, as they are perceived to be balancing home and work life well, whilst contributing to a supportive, ‘female-friendly’ culture. Few male trainees across the three specialties stated work life balance was of most importance to them except from in general practice. There does
appear to be some evidence to support that men are choosing general practice later in their careers after they are unsuccessful gaining a training number for other medical specialties. Therefore it may be that choosing a specialty with a perceived better work life balance, such as general practice, is more important later in men’s working lives as they start a family.

The survey data suggests that women from general practice and paediatrics are most likely to feel their gender has had an impact on their specialty choice, whereas few men across all three specialties feel this is the case. The female GP trainees feel their gender has influenced their specialty choice due to childcare reasons as the specialty is perceived to provide a good work life balance. However, female specialty paediatrics trainees feel their gender role of looking after children has steered them towards choosing paediatrics. Ethnicity does not appear to have significantly influenced specialty trainees’ choices, although the survey data does suggest that IMGs choose general practice as it is less competitive to gain a training number compared to other medical specialties, and this is explored further in the interviews.

The survey data both supports and challenges Elston’s (2009) framework (see Figure 3, page 54) regarding why women are entering certain medical specialties. The survey data does agree that women are more likely to choose medical specialties that they feel are more people-orientated (high patient contact), such as in paediatrics. Contrary to this, the data shows male GP trainees are more likely to choose general practice due to the high amount of patient contact compared to the female GP trainees surveyed. In addition, the survey also disputes that men are more likely to enter anaesthetics, as it is ‘less plannable’, as the survey data shows 64% of female anaesthetics trainees surveyed compared to 23% of male anaesthetics trainees feel they chose anaesthetics due to the work life balance. The findings from the survey informed part of the interview questions with specialty trainees to delve further into reasons for medical specialty choice, and why some aspects of choices appear to be gendered. The data from the interviews are discussed in the next section.
SECTION TWO: INTERVIEW DATA ANALYSIS - FACTORS AFFECTING MEDICAL SPECIALTY CHOICES

INTRODUCTION
The survey data analysis indicates that gender differences are present between male and female trainees regarding their medical specialty choices. These differences were investigated further through semi-structured interviews with survey participants who also agreed to participate in an interview. As noted in the context chapter (chapter three), a doctor’s career is not necessarily a linear process. With a wide range of medical specialties and subspecialties available to choose from, there are several milestones within a doctor’s career when they make career choices. As a reminder, typically, after a doctor has completed their medical degree, they must complete two years of foundation training. It is after this point that they are expected to begin their specialty training. However, some doctors decide before embarking on specialty training to have time out to work overseas, conduct research, to start a family or locum in their desired specialty to confirm their decision. These types of interruptions may also occur during specialty training and cause a problematic task for Health Education England (HEE) regions, in deciding how many training numbers to assign to each annual recruitment intake, as these factors mentioned prolong the years in training and thus reduce the number of training positions available for future doctors to fill if the number of training positions is kept constant. In addition HEE, together with the Royal Colleges, also organise the specialty training programmes, based on factors such as: the structure of the programme, training length and number of training places available (i.e. competitiveness of gaining a training number).

The interview data has been thematically analysed and codes assigned to the factors that appear to influence specialty trainees’ choices. These themes are labour market organisation of medical jobs, role models, specialty culture and, finally, controllable working hours.
LABOUR MARKET ORGANISATION OF MEDICAL JOBS

How training programmes are organised appears to influence specialty trainees’ choices especially for female doctors who plan to start a family, or already have children. These aspects of labour market organisation of medical jobs are organisation of specialty training programme, geographic stability, competitiveness of gaining a training number, training length and the training style.

Organisation of specialty training programme

The term ‘organisation of specialty training programmes’ refers to how doctors apply for specialty training. There are two different types of training programme – ‘run-through’ and ‘uncoupled’. A run-through training programme is where a trainee is required to apply for the full-length of their training programme once, so their training number is secure throughout the duration of their training regardless of whether they take time away from the training programme to have a baby, carry out a PhD, or other research. Paediatrics and general practice are both examples of run-through training. In contrast other specialties, such as anaesthetics, are referred to as ‘uncoupled’ as specialty trainees are required to reapply after two to three years of core training to progress to the next stage of their specialty training. Therefore there is no guarantee of gaining a place to continue with the training programme, as competition can be high.

The interview data shows that the majority of female trainees specialising in paediatrics have, in part, chosen this programme due to the way it is organised so they have the security of maintaining a training number. Female paediatric interviewees commented on how the ‘run-through’ training programme was a factor when choosing the specialty. However just one of the men interviewed mentioned run-through training was a draw for them. For the female paediatric trainees who mentioned this as a reason for specialty choice, it was felt that run-through training provided more job security and stability if they chose to start a family. The long length of paediatrics’ run-through training means that female trainees can take maternity leave during their training programme without running the risk of having to secure a new post whilst
pregnant or whilst their children are very young. For example, when one female paediatrician with a child was asked about planning for a family, she said:

“I think it was quite nice to know that once you were on the programme, provided that you do what you’re supposed to that you’d be alright for eight years and that you’d probably get a job at the end of it” (Female paediatrics trainee, Interview 25).

This quote shows that women are attracted to specialties which provide more job security and it also shows that workforce planning should take run-through programmes into consideration when assigning training numbers, since it is likely that specialty trainees will take longer to complete a run-through training programme, particularly for maternity and childcare reasons. Research by Jolly et al (2016) compared surgical specialties completion times based on whether the programme was run-through or not, and found that two thirds of run-through trainees took an additional one to three years to complete their specialty training compared to those completing ‘uncoupled’ training programmes.

**Geographic stability**

As highlighted in the context chapter (chapter three), geographic stability is more achievable in certain medical specialties. For example, general practice is the only specialty within this research that does not require trainees to work in a different location every six months, whereas most hospital-based specialties are the contrary. In addition GP trainees can usually choose a GP Practice that is close to their home. Interview data from female trainee GP respondents show that geographic stability was an important factor when choosing general practice because they can achieve greater stability within their home lives, such as buying a property and factoring in a consistent commute time into childcare arrangements. Therefore GP trainees can achieve much more geographic stability compared to those in hospital specialties, who can be posted to a hospital anywhere within their HEE region on a six-month rotation. For example, one female GP trainee explained how geographical stability enables her to manage her childcare arrangements:
“The big, massive thing with medicine was the fact that you could be moved anywhere within the [location region] at six weeks notice. And when you have a family and you’re settled and have a house, you can’t just up sticks and move. So, if I was given a job in [location] it would have been a two and a half hour commute, so for me it was a bit like ‘I can’t move my family so what do I do? Do I leave my child for a week and work somewhere else?’ So that was a big…that was a massive thing actually that I’d forgotten about because it’s been a year since I made that decision” (Female GP trainee, Interview 2).

Similarly, another female GP trainee with childcare commitments also commented on how she chose GP due to achieving geographic stability:

“I think one thing that is good with general practice is once you’re on the training, you’re in one region. Whereas, for example, if you go into medicine or acute medicine you can move a lot between different deaneries\(^\text{11}\) and different years, which is hard for me when I have a step-daughter…we have her living with us 50% of the time…I can’t move around all the time, every year, because I’m kind of tied up with other commitments and that’s hard when you’re in medical training because they expect you to move at a drop of a hat to whatever hospital you get placed at”. (Female GP trainee, Interview 24).

The interview data shows that the majority of female GP trainees are more influenced to choose general practice because of the geographic stability of the specialty, compared to male GP trainees. This finding implies that women are responsible for the majority of the childcare and choosing a specialty that appears to suit that need.

**Competitiveness of gaining a training number**

The interview data also shows that the amount of training numbers available for each medical specialty has an impact on medical specialty choice. At the stage where doctors are choosing a medical specialty to specialise in, competition ratios are published to indicate to prospective trainees how likely it is they will successfully gain a place on a training programme. According to information produced by HEE (2016) at the time of data collection, general practice had one of the lowest competition ratios with 1.28 applicants for every post available. Paediatrics was slightly more competitive with 1.65 applicants for every post available, and anaesthetics attracted 2.09 applicants per every post available. In 2016, surgical specialties had the highest

\(^{11}\) “Deanery” was the previous term to describe HEE regional centres.
competition ratios, such as a competition ratio of 10.17 for cardiothoracic surgery, due to a combination of limited places available and a higher number of applicants.

The competitiveness of gaining a place on a training programme appears to have a gendered effect on specialty choice, particularly for the male GP trainees interviewed. The majority of male GP trainees interviewed commented they chose general practice because it was less competitive, compared to their desired surgical specialties, where they had not previously been successful, or thought it was too difficult, to gain a training number. For example one male GP trainee, who had not secured a training number in oral and maxillofacial surgery, said:

“After a number of years trying to get a higher registrar training in a relatively small specialty with high competition [oral and maxillofacial surgery], I never got to finish off my specialised training. So I had the choice of carrying on as a staff grade surgeon or think about other career options. In the end, with the current climate in general practice, it seems as though there are more job opportunities available in general practice.” (Male GP trainee, Interview 15).

This interview response also refers to the current recruitment crisis within general practice, as mentioned in the context chapter (chapter three), implying that career opportunities post specialty training are also better than other medical specialties. The interview data with male GP trainees enabled elaboration of the findings from the survey data that show gender and location of medicine degree associated with the GP specialty choice. The survey data shows that men who have studied outside the UK are more likely to choose general practice as a second choice because it is seen as less competitive than their desired specialty, or they have been unsuccessful with gaining a place on another specialty training programme. A male trainee GP interview respondent, who had completed his medical degree in Nigeria, commented on how he felt he would not secure a training number in orthopaedic surgery in the UK, despite working as an orthopaedic surgeon in Nigeria. Therefore, he chose to specialise in general practice as it was deemed to be less competitive:
“[Surgery] wasn’t an option for me because...to be honest, I was told by some of my senior colleagues I worked with in orthopaedics that it is difficult to get a place because of the competitiveness” (Male GP trainee, Interview 17).

The responses above show that the majority of men applying for GP training (because of the likelihood of gaining a place on the programme) do so based on either genuine experiences of not gaining a place on other training programmes, or the perception of not being able to gain a place. From the interviews, it does seem as though those who have not completed their medical training in the UK make perception-based decisions rather than actually being unsuccessful when applying for another specialty. These perceptions may be based on the application process for medical specialties, since those who have completed some of their training in the NHS gain more points and thus are more likely to gain a place. General practice is the only specialty that does not have the points-based system within its recruitment process and, as seen from the earlier survey data, some IMG respondents comment that examinations are much more difficult for them. Therefore this may be why it is perceived to be less competitive to gain a place in general practice, and there are fewer examinations, combined with lower numbers applying for a larger number of training posts.

Training length

As seen in the response above from the male GP trainee (interview 17), the shorter length of training was also seen as a draw for trainees in general practice. Six out of the seven GP trainees interviewed wanted a training programme of a shorter length so they could qualify more quickly. Even though men and women both felt the shorter training length was a draw towards general practice, the benefits of a shorter training programme were different for male and female GP trainees. For the male GPs interviewed, the opportunity to complete training sooner, in order to progress their careers more quickly, was a key attraction for those who stated shorter training length as a factor. In contrast, the female GP trainees interviewed felt the ability to work fewer unsocial hours sooner was the main attraction for choosing a medical specialty with a shorter training length. For example, one female GP trainee said:
“The training structure...just the fact that it’s a little bit shorter and then you’re in control of what you do and don’t, I think that was it. So yeah the fact that it was shorter definitely was appealing because it just meant less years of shift work and nights and weekends.” (Female GP trainee, Interview 2).

Again, this is an example of how women are more likely to choose medical specialties which are structured and organised in a way that lend themselves well to balancing work and family life. From the interviews, the way general practice is organised seems to have the most benefit to female specialty trainees in terms of having children, since it is run-through, of shorter training length and has geographical stability. On the other hand, male trainee GPs appear less persuaded by these attributes of doctor labour market organisation for childcare reasons, and instead have been attracted by the high number of places available to qualify and progress their careers more quickly, particularly if they have been trying to gain a place in another specialty for while. For example, a male GP trainee said:

“a shorter training programme with a way to get out, with an end point is a big attraction, definitely” (Male GP trainee, Interview 15).

Training style

Not all of the findings concerning reasons for specialty choice are gendered. For example, training style in anaesthetics was a main factor for both male and female trainees choosing the specialty. The interviews with anaesthetics trainees confirm that the style and organisation of training had a significant impact on their specialty choice, since two thirds of the trainees interviewed mention how the ‘apprenticeship-model’ style of training attracted them to specialise in anaesthetics. The apprenticeship-model approach involves the trainee being partnered with a consultant anaesthetist during each shift, throughout the duration of their training. Other research has found this approach to training is beneficial to trainees as they can practice many different types of procedures and experience meeting as many patients as possible, with varying medical issues (Garvin et al, 2008). In addition, a close relationship can be formed between the trainee and consultant (Hallam et al, 2013), so constructive feedback can be given to the trainee and thus the progression of a trainees’ competency can be closely monitored. Tsouroufli and Payne (2008, pages 5-6) found trainees felt the
The uniqueness of anaesthetics training style described by the majority of anaesthetist trainees seems to reflect anaesthetics “forward thinking” (Male anaesthetics trainees, Interviews 4 and 5) on a number of employment issues, such as the availability of LTFT training that is discussed later in this chapter. It could be said that anaesthetics has responded to a changing workforce in terms of more women entering, but also recognises the pressures the NHS is under during economic austerity and cuts to funding. From the interviews, it appears that anaesthetics, as a specialty, have made
sure teaching is also at a high level. A male anaesthetics trainee describes the differences in teaching in anaesthetics compared to general medicine:

“The teaching and the training are much better in anaesthetics than it was in medicine. So you’re with a consultant everyday, so you’re always getting teaching...whereas in medicine it was self directed and the quality of teaching you received wasn’t very good and the one to one teaching you got wasn’t as good, wasn’t as organised. Anaesthetics is much better for all that, it’s much more organised” (Male anaesthetics trainee, Interview 18).

This difference in training, again, is probably due to short staffing in A&E and core medicine not allowing for one to one training, along with the sessional nature of the work in anaesthetics allowing for the apprentice-model of training to be available. The interviews do suggest that the majority of female anaesthetics trainees enjoy this aspect of anaesthetics training, so perhaps has helped encourage more women to enter compared to other medical specialties, but it appears that male anaesthetics trainees are also drawn to the specialty for this reason also. It should be noted here that the state’s actions, in terms of austerity measures, has contributed to specialty trainees opting not to choose specialties that appear to have been hit the worst by cuts to primary, secondary and social care funding and resources, such as A&E.

Role models

The interviews with the female paediatrics trainees confirm that senior female role models were an influential factor for them when choosing the long-standing female-dominated specialty of paediatrics. Senior female role models were seen as important in helping trainees to visualise balancing family life whilst also working in a hospital-based specialty - a role which is commonly characterised by long, unsocial working hours. The majority of the female paediatric trainee respondents commented that they see many female consultant paediatricians working part time so they can work in a senior role and have a family life. For example, one female paediatrics trainee, in her first year of training said:

“I’ve got a few friends who are paediatric trainees a few years ahead of me, and I know they have taken time out and I always kinda related that as good for
going part time as well, so that was definitely a bonus, especially as a woman...working with other paediatricians made me realise it’s worth it, you can work around it”. (Female paediatrics trainee, Interview 8).

Similarly, another female paediatrics trainee stated that she saw working part-time through job sharing was more amenable in paediatrics, mainly because it is a medical specialty that has been female-dominated for a long period of time:

“You can notice there’s more women in paediatrics...and because more women choose to go into that profession, I think they’ve had to make it more able to provide the ability to job share or go part-time because I think if more women are attracted to that specialty they have to kind of be able to compromise. So thinking of it from that point of view, I thought ‘right well, I’ve seen other doctors and other women be able to job share or go part time and I think that’s option for me’”. (Female paediatrics trainee, Interview 10).

These findings endorse the arguments found in other research concerning medical career choices and the influence senior role models can have on medical specialty choices (Wright et al, 2002; Steele and Fisman, 2013; Al-Nuami, 2008). However, due to the quantitative nature of these studies, it is not known why these role models were seen as influential. As described by the female paediatric trainees in this study, it was a way to visualise an achievable work-life-balance whilst working within hospital medicine. However, the interview data also shows the way senior role models are perceived may be dependent on gender. For example, the majority of male paediatricians interviewed commented that senior male role models attracted them to the specialty, not for work life balance reasons, but instead to focus on highly specialised sub-specialties of paediatrics. For example, one male paediatric trainee commented:

“I looked down the list of [specialties] that were left and there was this one called paediatric [sub-specialty] with this chap called [name] and he’s the chap who said you’re very good, you’d be a good paediatrician, and I thought ‘well he seems a nice chap so right I’m going to go off for five weeks working with him’...you meet some of these people in your career, and I’ve met two or

12 This sub-specialty title has been omitted through the request of the respondent to allow for their anonymity, as the number of specialty trainees within this sub specialism in England is very low.
three and you think ‘actually that’s the kind of doctor I want to be’ and that’s sort of the person he was”. (Male paediatrics trainee, Interview 6).

The study conducted by Al-Nuami (2008) in the UK, found that medical students from the University of Manchester ranked ‘influential role models’ as the eighth most important factor for choosing a medical specialty, on average. However, when comparing factors influencing medical specialty choice between men and women, Al-Nuami (2008) found that men ranked role models as an influence on specialty choice more highly than women. Comparing the results from this research, perhaps it could be argued that female doctors are making these decisions subconsciously, as one female paediatrics trainee noted:

“I think there must have been something subconscious that I could see… I liked the people I was working with and I liked the team and that was probably a lot to do with it, that there was quite a good ratio of men to women – so it had a good atmosphere. It wasn’t like going into orthopaedic surgery where, as a woman, you feel quite kind of isolated. So yeah I think that probably did play a role but I don’t quite remember thinking when I applied for paediatrics: ‘I think paediatrics will be good for me as a woman’ but yeah I think it definitely influenced me” (Female paediatrics trainee, Interview 13).

The gender ratios of senior role models also seemed to impact on the way some specialty’s cultures were perceived, which also contributed towards gendered decision making, as discussed below.

SPECIALTY CULTURE

The interview data shows that a specialty’s culture was a factor for specialty choice for the two hospital-based specialties for both male and female trainees. In paediatrics the culture was often referred to as “friendly”, “nice” and “fun”. Six out of the fourteen trainees interviewed felt the presence of children in the workplace environment contributed to this culture. For example, a female paediatrician said:

“Generally people that work with children are quite nice. You know you can’t be shouting and being mean to people around children, although you can’t do it around adults either, people seem to think that’s more acceptable.” (Female Paediatrics trainee, Interview 1).
However, the culture in paediatrics is felt by over half of those interviewed (both male and female) to stem from the fact it is a female-dominated specialty, and that female paediatricians contribute to the supportive nature of the specialty. A male paediatrics trainee said:

“When I say the atmosphere, I mean it’s a lot friendlier and a much nicer environment to work… I think definitely, it’s a lot more family-friendly because of women taking up paediatrics and I think the female presence in paediatrics sort of contributes to that culture of being a lot more supportive” (Male paediatrics trainee, Interview 3).

As highlighted in the quote above, and the earlier section, the majority of the paediatrics trainees interviewed felt that more women in paediatrics contributes to a culture that is accepting of part-time work and childcare arrangements. For example, “people appreciate that you might need to get home to pick up the children from school or nursery” (Female paediatrics trainee, Interview 25).

Specialty culture was also a main factor for anaesthetic trainees when choosing their specialty, but it was based on slightly different reasons to paediatrics. The culture of anaesthetics was frequently described as “laid back”, “relaxed” and “supportive”. The comparison with the culture found in surgery was often used as a reason for specialty choice for anaesthetist trainees. For example a female anaesthetist trainee commented on how the culture in anaesthetics is much more laid back due to the way anaesthetists present themselves, she said:

“When I see the surgeons there with their three piece suits, or perfect dresses with high heels and nice cars, I thought I couldn’t really do that. I quite like slopping around and anaesthetics is probably the only specialty where you can turn up to work in a hoodie and UGG boots and no one bats an eyelid, and then we get into scrubs and spend all day in pyjamas. There’s a certain casualness to it, I think it’s because it’s high stress and we know it’s high stress that we’re casual in other ways… I don’t like the flashy status of other specialtites, I like just getting on with things in the background” (Female anaesthetics trainee, Interview 12).
Unlike paediatrics and anaesthetics, GP trainees did not mention the culture of general practice being a factor when choosing their medical specialty. Perhaps this is because general practice is not hospital-based, so there is a perception of much less team working, as the nature of the work in general practice is more individualised. Gibson et al (2018) confirm this as they find GPs are less likely to rate that they experience working within a team as a part of their daily job role.

**CONTROLLABLE WORKING HOURS**

The interviews show that ‘controllable’ working hours are becoming increasingly important to both male and female trainees across the three specialties. The term ‘controllable’ has been used because it is associated with both the ability to not work weekends and nights, and also with the ability to work regular, and thus more controllable, shift patterns. ‘Work life balance’ is not used here because, in reality, trainees from GP and paediatrics stated that the work life balance is not actually very good now they are in training. For example, almost half of the GP trainees said the work life balance is not good as the work is more intense due to shorter ten-minute appointments and the vast volume of patients to deal with. To highlight this, when asked whether he enjoys working in general practice, one male GP trainee said:

“I thought GP was going to be good [for work life balance] but it’s just as busy as the other specialties” (Male GP trainee, Interview 17).

The option to not work nights and weekends, once qualified, was an important factor for all of the female GP trainees interviewed - to facilitate in planning a family. In general practice, five of the seven interviewees stated controllable working hours as a main factor for choosing GP, four of these being all the female GPs in the sample. Three of the GP trainees interviewed had children, which had an impact on their specialty choice as they wanted more control of whether they worked weekends or on-call after training. For example, one female GP trainee said:

“I have purposefully chosen a career that doesn’t have much of the ‘wow factor’ just because I know that later on I will regret choosing something that gives so much of my other time to do it. I don’t want to give up my life for medicine...
I’ve gone into medicine thinking about, if I did want children, about choosing a career path that would be friendly to having a family at the same time. So, definitely, yeah, and having maternity leave and being able to have more flexible working hours...I’ve definitely chosen it with that in mind” (Female GP trainee, Interview 14).

This female GP trainee also mentioned she originally wanted to specialise in oncology but saw her older sister quit cardiology training and retrain as a GP because she struggled with the long, unsocial working hours associated with hospital medicine. Similarly, another female GP trainee interviewed mentioned she chose general practice because of the perceived controllable working hours being better than in cardiology. She said:

“I did core medical training originally. I was thinking about becoming a cardiologist, I really do love cardiology...But the stresses were just really high. I was seeing my colleagues who were medical registrars quitting because of the demands on, not only on the rotas, but then the nature of the work when you were there. They were thoroughly exhausted when they were getting home at the end of the day... I was just seeing my colleagues who had young children, particularly the female colleagues who have young children, coming in on one or two occasions having to bring their children in, in the staff room because they were called in at such short notice to work a shift. And I just thought, I don’t think I want this for me or my family you know so, as much as I love the specialty, I love my family more...a big part of GP for me was being able to have a little bit more control over my work pattern” (Female GP trainee, Interview 2).

Likewise another female GP trainee decided not to specialise in A&E because she felt more able to achieve controllable working hours in general practice. When asked why she chose to specialise in general practice she replied:

“There are certain careers within medicine, that are better suited to women, and general practice is one of the main ones really. Just because it’s easier to work less than full-time and to try and juggle things...I didn’t apply for [general practice] straight away because I’ve got an interest in emergency medicine, so my other interest was A&E. So I wanted to give that a bit more of a try before I decided and so I took a clinical fellow job and worked in A&E for nine months and I really liked the job...but the rota was very hard going and me and my partner nearly split up over it because he just never saw me. I worked seven days on and they were always ten-hour shifts and I’d always have to stay an hour late as well, or two. So you do seven days in a row, have two days off and
then you’re back on again...So general practice allowed me to work where I saw my family a bit more”. (Female GP trainee, Interview 24).

Within anaesthetics having controllable working hours was a factor for choosing the speciality as there is less continuity with the majority of patient care, because once the full anaesthetic procedure has been carried out, the patient is then taken away to another ward or discharged from hospital. This means a lot of the work can be conducted in regular shift patterns that are much more controllable than in other hospital specialties, such as core medicine and A&E. The vast majority of the male anaesthetics trainees interviewed stated that controllable working hours were a major factor when choosing the speciality. However women did not state that the regular shift patterns were a draw, more so that the lack of patient continuity meant they were not worrying once they returned home from work. For example, one male anaesthetics trainee described how the controllable working hours in anaesthetics was a draw for him:

“It was quite clear with the changes in the [junior doctors] contract and the way training was going to be done, that with the change in training recommendations that medicine would just be very, it wouldn’t be a very nice lifestyle, in the sense that I would be doing increasing weekends and increasing nights. Even as a consultant I would be doing nights and in a job that I didn’t really enjoy very much and that was a very, very high-pressure environment. One where I would be frequently coming in very early and staying very late. I was quite worried about the impact that would have on the relationship between me and my wife longer term and also when we plan to have children, the effect it would have on my family as well. It’s just...the way it’s set up, you always have responsibility for patients whereas anaesthetics is more sessional based so you can turn up and do a list for a day and then the following day those patients go back to the ward to the parent team so someone else can take over whatever list you’re doing, there’s no need for continuity which is beneficial in terms of lifestyle” (Male anaesthetics trainee, Interview 5).

Another male anaesthetist felt the working hours in anaesthetics are more compatible with having a work life balance compared to other medical specialties. In addition the work intensity also appears to be less compared to other hospital specialties, such as A&E and core medicine:
“The work life balance in anaesthetics is vastly superior to that in medicine. So in medicine there’s all these exams and as a registrar I was still running around doing all these things I was doing as a house officer and sort of junior SHO in terms of the clinical stuff I was doing. There’s more of it, so you felt like a dog’s body and doing all this stuff 95% of the time that anyone could do and it was only 5% of the time where you felt you’re really engaging your brain and the knowledge you’d accrued and skills you’d developed. So it was quite a frustrating area to work in. It’s like you’re busy all the time with so little gain and you’re still kind of busy in anaesthetics and ICU but you get a lot more job satisfaction and the job is more rewarding so it seems less like hard work”.
(Male anaesthetics trainee, Interview 18).

This quote above shows, again, that both the training style, as well as the higher staffing levels, within anaesthetics contributes to more controllable and less intense patterns of working time. There also appears to be a link to training standards being perceived as better in anaesthetics because of this. Although this research has not looked at A&E and core medicine as specialties, the interviews with specialty trainees who had previously trained within those specialties imply that the shortage of staff and pressures within those specialties contributes to more intense working hours and consequently a lower intensity of training as fewer consultants are available to directly support them and the work content is seen as more administrative than clinical.

**CONCLUSION**

Overall the empirical data in the chapter shows that the organisation of the medical labour market is a key shaper of specialty choices, particularly for female specialty trainees. As the literature review highlights, women still hold the majority of childcare responsibilities (Lyonette and Crompton, 2015), and the data within this chapter shows how women often make specialty choice decisions based on having childcare responsibilities. The way specialty-training programmes are structured and organised creates medical specialties that are perceived by prospective trainees as more amenable to balancing work and family life, and as a consequence this plays a role in creating the horizontal gender segregation evident within medicine. For example, in paediatrics and general practice run-through training adds stability and job security for female trainees who plan to start a family as their training number is secured for the entirety of their specialty training. In addition, the geographic stability and lack of
unsocial hours work within general practice attracts female trainees as this style of training is perceived as more conducive to having a family compared to most hospital specialties during a period of women’s lives when they are likely to want to start a family. It should be noted there is evidence that working hours within general practice are similarly long and intense as hospital-based specialties, and this is explored further in the next empirical chapter.

Even though the shorter training length in general practice was a driver for both men and women, it appears that this is for different reasons depending on gender. For men, the shorter training programme allows them to progress their careers more quickly to earn a higher salary as a qualified GP, whereas women tend to opt for a shorter training programme so they can work part-time sooner on a higher salary compared to trainee level. In addition, the competitiveness of training programmes is seen to have a gendered impact within general practice as men, particularly those who have completed their medical degree outside of the UK, tend to opt for general practice when they have not been successful in gaining a place on a more competitive specialty programme, or they feel they would not gain a training number on a more competitive training programme. Therefore the shapers of training programmes and training numbers, i.e. the Royal Colleges of each specialty and HEE regions, do appear to play a key role in the gendered decision-making seen across the three medical specialties.

The acceptability of LTFT training is also seen to be a key determinant of specialty choice for female trainees across all three medical specialties, particularly so for the hospital-based specialties where hours are unsocial and the training length is much longer. All three medical specialties within this research are reported as accepting of working LTFT. In paediatrics this is due to more female consultants already within the specialty creating a culture of working part-time through job sharing, and similarly general practice has a culture of being accepting of part-time work due to the nature of the working time not including nights and weekends. However, anaesthetics is male-dominated at consultant level so it seems that the nature of sessional work, alongside a lack of patient continuity, is conducive to part-time shift work without intentionally organising work with this goal in mind. In addition anaesthetics appears
to have a ‘friendly’ and ‘supportive’ culture due to the apprentice style training model, and also there is the impression that this is deliberate to differentiate the specialty from the stereotypical ‘macho’ and patriarchal surgical specialties whom anaesthetists work very closely with.

However, not all specialty choice reasons are entirely gendered. Both men and women in paediatrics and anaesthetics showed they were attracted to hospital specialties, and likewise both men and women in general practice showed they placed achieving a work life balance as the most important driver for choosing general practice. In the next chapter, the employment experiences of specialty trainees are examined to establish whether there are gendered work experiences within medical specialties, and how the state and associated institutions may influence these experiences.
CHAPTER SIX
EMPLOYMENT EXPERIENCES OF SPECIALTY TRAINEES

INTRODUCTION
This second empirical chapter focuses on the next stage of the medical career trajectory, by exploring the employment experiences of specialty trainees whilst they are working within their chosen medical specialties. The complexities of the medical profession in England outlined in chapter three provide an important context for understanding the employment experiences specialty trainees face. The medical profession is traditionally perceived as ‘elite’, male-dominated and is characterised by extreme working hours. The profession also has its own idiosyncrasies in terms of how working time is organised and perceived, and how medical careers and training programmes are structured, as discussed further in the context chapter (chapter three). In addition, the profession is largely bound to the public sector, so is consequently reliant on state funding and heavily influenced by state decision-making.

Now more women are entering the medical profession, this raises the question of whether this distinctive context, which has been predominately characterised by employment characteristics synonymous with typically masculine working practices and elite professional status, would cause challenges for female specialty trainees as women continue to enter the profession at a greater rate than men.

Interviews with thirty specialty trainees in anaesthetics, general practice, and paediatrics, from the same HEE region, inform most of this chapter, which centres around the main challenges specialty trainees face on a day-to-day basis whilst working within a relatively unique and complex professional context. To supplement the specialty trainee interview data, the findings are also informed by a total of nine interviews with BMA officials (n=4), Training Programme Directors (TPDs) from each medical specialty within the HEE region (n=3), and Chairs from the RCA and RCPCH (n=2). The interview data has been thematically analysed, with three main overarching themes emerging from the data analysis. Each main theme represents a main challenge faced by specialty trainees within their chosen medical specialties. The first
theme: ‘managing and coping with working time’, concerns what it means for specialty trainees to manage and cope with their working time within a context of extreme and varying working hours. The second theme: ‘managing and navigating through careers’, encompasses ways specialty trainees manage and navigate through their careers, from career progression to planning family life around their career. The third theme: ‘pay and status of the medical profession’, brings together issues respondents raised surrounding equal pay and how the recent feminisation of the medical profession may have contributed to a change of the status of medicine and medical specialties. Within these themes, codes and sub-codes have also been assigned from the interview data that are identified throughout the chapter. This chapter is split into three sections, where each theme is discussed in turn.

SECTION ONE: MANAGING AND COPING WITH WORKING TIME

BACKGROUND – PROBLEMATISING WORKING TIME IN MEDICINE

The way specialty trainees manage and cope with working time emerges as a main theme from the interview data. Before presenting the analysis of this theme, the complexities of working time in medicine should be outlined, as it is these complexities that specialty trainees work around in order to manage and cope with their long working hours. Firstly, there is the issue of the definition of full-time and part-time working hours in medicine, compared to standard full-time and part-time working hours in most other professions/occupations. In medicine, full-time working hours are scheduled as an average of 48 hours per week over a period of 17 weeks, to adhere to Working Time Regulations (1998), a part of the European Working Time Directive (EWTD). These scheduled full-time working hours are higher than the standard UK full-time average of 36.9 hours per week (ONS, 2018b). Therefore part-time working hours in medicine could be around 28 hours per week, based on the usual 60% of standard full-time working hours and 50% of on call working hours. This means part-time working hours in medicine are also much higher than the standard UK average for part-time workers of 16.3 hours per week (ONS, 2018c), and are much closer to, or
often the same as, standard UK full-time working hours particularly, as is discussed below, if work at home outside of paid hours is taken into account.

Secondly a career in most medical specialties, especially those that are hospital-based, involves working unsocial hours during weekends and nights. Working unsocial hours is less frequent during general practice training compared to the hospital based specialties of anaesthetics and paediatrics, since only six months of general practice training is completed within the hospital setting. Thirdly, it is common for specialty trainees to work beyond their weekly scheduled clinical working hours due to additional work associated with completing their training programme requirements, such as the ePortfolio and revising for exams, as well as clinical work such as patient handovers after a shift (Morrow et al, 2014).

This unique context of working time in medicine, alongside the literature on working time in professions, prompted the exploration of how specialty trainees experience working time and how they attempt to achieve some sort of balance between work life and their home life, if at all. Indeed, “balance” is arguably too strong a term when it is known that specialty trainees regularly work excessively long hours. Interview data shows evidence of the challenges specialty trainees face when managing and coping with these complexities surrounding their working time, and that the combination of these facets of working time creates a blurred line between their working lives and their personal lives. It can be also be seen from the interview data that specialty trainees’ experiences of working time is gendered, which is discussed further throughout this theme and related codes, with female trainees more likely to encounter negative consequences of working time in medicine. There are three related codes that stem from this main theme: ‘managing and coping with working time’. The first is the length and unsociability of working hours, the second is rota/appointment planning, and the third is experiences of working Less Than Full-Time (LTFT).
LENGTH AND UNSOCIABILITY OF WORKING HOURS

The interview data revealed four main issues relating to the length and unsociability of working hours that create challenges for specialty trainees when attempting to manage and cope with their working time in order to achieve some form of work life balance. First, the majority of respondents state they regularly work outside the home beyond their scheduled average weekly working hours. Second, the additional work required to complete their specialty-training programme lengthens their weekly working hours even further, through additional work at home during their personal non-work time. Thirdly, respondents comment on the negative impacts of working unsocial hours. Fourth, specifically for hospital-based trainees, commuting to a hospital far away from their home is identified as adding more hours onto their working week and makes balancing home and work life increasingly difficult.

Despite already being scheduled to work longer working hours than the standard UK average, interviews show that all full-time and LTFT respondents frequently work beyond their scheduled clinical working hours. Respondents state this happens for two main reasons. The first is that the nature of the work does not always allow specialty trainees to finish work when their shift is scheduled to end. When asked how many hours he works per week, one full-time male trainee anaesthetist said:

“Probably somewhere between 50 and 60 [hours]. I know it says 48 but realistically if I’ve got a patient on the table, and it’s 5 o clock, I’m not gonna get up and walk out of theatre and go home at 5pm just because that’s my designated clocking off time. That’s the thing the government don’t really seem to grasp that if I’m in the middle of something...I’m not just gonna ditch the patient because they’ll die.” (Male anaesthetics trainee, Interview 4).

This quote highlights that the intrinsic nature of medical work means that it is difficult for specialty trainees to leave work on time if in the middle of a clinical procedure, such as during an operation or a handover. Secondly, respondents commented that they are required to do additional work to complete their training programme that is not normally possible to fit within their scheduled and paid work hours. Although specialty trainees are granted 30 days of study leave per year to complete the additional work that contributes towards the successful completion of their training
programme, all respondents stated that the majority of this additional, non-clinical work is carried out in their personal time, for no extra remuneration.

Respondents commented that some forms of additional work are essential in order to successfully pass their training programme. This includes studying for, and revising for, specialist exams to join the Royal Colleges and developing their ePortfolio. The completion of the ePortfolio during training is mandatory for all specialty trainees across the three specialties. The purpose of the ePortfolio is for specialty trainees to log evidence that they are gaining the key competencies throughout their training, which are then authorised by their Educational Supervisor. Specialty trainees are required to be reflective in the evidence they log, so many respondents commented that they are expected to complete their ePortfolio consistently every week, which adds more, frequently unpaid, working hours to an already long working week. When asked about the ePortfolio, one female trainee GP said:

“It takes a lot of time...you end up spending a lot of your own time doing it a lot of the time. It can easily be a couple of hours a week just on the portfolio and that’s before you’ve done any studying or anything like that...it is certainly demanding and it’s unpaid” (Female GP trainee, interview 2)

As well as this essential work, respondents also commented that there are other forms of additional work, which are seen as advantageous to have on their CV but not essential to successfully complete their training programme. This non-essential work includes: teaching medical students, carrying out research, completing postgraduate courses in leadership and conducting multiple audits each year. Some respondents refer to these forms of additional work as “brownie points” (Female anaesthetics trainee, interview 7) to improve the look of their CV.

The interview data shows there are differences in the way respondents choose to manage their essential and non-essential additional workloads, based on their childcare responsibilities and the likelihood of improving their career progression. The interviews show that most trainee GP respondents focused only on completing the
essential additional work, since there is a higher number of salaried GP and GP Partnership posts after training, compared to fewer consultant posts available for the number of hospital-based specialty trainees. The higher number of salaried GP and GP Partnership positions is widely viewed by trainee GPs to be due to the current recruitment crisis in general practice. Thus GP respondents felt they would easily gain a salaried GP or GP Partnership position after their training regardless of how much additional work they carried out. For example, when asked whether she felt not carrying out additional, non-essential work was a hindrance to her career progression, one female GP trainee said:

“I think because it’s a relatively under filled specialty, it in some ways gives me more options...I can easily walk into a job from one week to the next because there’s a shortage everywhere...I have a friend who’s qualified who just wanted to do a bit of salaried GP work on a short-term basis and had four offers of a Partnership by the end of the week without going to any interviews because they’re desperate...There isn’t any problem at the moment finding work because there just aren’t enough GPs to go around.” (Female GP trainee, interview 2).

In contrast, most respondents from hospital-based specialties placed much more emphasis on completing non-essential additional work due to future consultant posts being more competitive to achieve, in anaesthetics and paediatrics, and commented that they are actively encouraged by their superiors to conduct further work in their own time to increase their chances of gaining a consultant post after completing their training programme. For example, many hospital-based respondents said they took part in teaching medical students and frequently conducted audits on the basis that it would improve their CV and subsequent chances of gaining a consultant post after training:

“The more senior you get the more you’re encouraged to take on extra things. So one of my extra jobs at the moment is that I organise lunch-time teaching on a Monday...I do the timetable and collect the feedback and I do all of that from home because I don’t have the time to do it in work, or I get in early or stay late. I also run the communication meeting that we have monthly... I do all of that in my own time. Then on top of that I have an audit to do, we all have to do at least one a year. I have done one already but I have another one coming up that
I have to do in my own time. I am currently doing a research project where we’re doing a systematic review and I am doing that completely in my own time... So you do all of that kind of stuff in your own time... but it’s things like that you need to have on your CV to show you have management experience, and that you have willing, and that you’re the type of person who would organise those sorts of things” (Female paediatrics trainee, interview 1).

However, it can be seen that the large amount of additional work does have a gendered impact on specialty trainees, since the interview data shows that carrying out additional work is problematic for respondents with childcare commitments, most of whom are women. In order to manage their working time, respondents with childcare commitments comment that they struggle to complete all of the extra work and therefore often, or always, have to refuse to carry out the non-essential additional work in their own personal time due to not having allocated work time to do so:

“I do my portfolio and I will be starting to revise for my ATT exam and then after that my CSA exam. So those things will all come outside of my current job. I don’t do audit in my own time, I have just done a big audit but I was given work’s time to do that. That was in psychiatry. Prior to that in paediatrics they asked me to do an audit but didn’t give me any work time to do it and expected me to do it in my own time so I just refused. I’m fairly assertive when it comes to things like that. So for me I just concentrate on exams because they’re non-negotiable. Anything else that’s extra, I do in work’s time. I certainly didn’t use to be like that, I used to do loads in my own time like audit and research, the works! But that all changed when I had my little one, my priorities changed.” (Female GP trainee, interview 2).

It should also be noted that half of the male anaesthetics trainees interviewed had opted to work LTFT hours, all for childcare reasons, having previously specialised in A&E, and core medicine. They also commented on the struggles of completing additional work in their own personal time:

“I spend a lot of our free time and days off doing work related things that we’re not getting paid for doing but they’re expected for you to do as a trainee...Like next week I’ve got to do a presentation for a teaching session, I won’t get time off work to do that and they won’t say “why don’t you have Wednesday afternoon off to prepare your presentation” so I’ll have to prepare it in my own time... it’s been a real struggle to keep on top of it most of the time” (Male anaesthetics trainee, interview 18).
These findings relating to additional work raise a number of potential challenges for those who take major responsibility for childcare, most of whom are women. Not only does additional work during non-paid, personal time have a detrimental impact on the amount of time specialty trainees can spend outside of work with their children, those with less evidence of additional work on their CV could be disadvantaged in the recruitment process for jobs after training. Respondents have not reached the completion stage of their training programme so it is unknown whether this would be an impact. However, many respondents from the hospital-based specialties of anaesthetics and paediatrics commented that completing both essential and non-essential additional work is seen as being advantageous in the consultant recruitment process.

“So this week I’m on annual leave but gave up my Wednesday afternoon to do some teaching. We have to, well we don’t have to, but it’s advised very strongly that we do diplomas in modules in postgraduate education and medical leadership if you want a consultant post in anaesthetics. So your work for those is in your own time, that’s what I have been doing this afternoon so, again, on my annual leave” (Female anaesthetics trainee, interview 16).

When this respondent was asked whether she felt carrying out this additional work would help her career progression, she replied:

“Yes and no. It’s not necessarily that they will improve my career progression but not having them would hinder my career progression” (Female anaesthetics trainee, interview 16).

This was also the case for anaesthetist respondents in the preliminary core stage of their training programme, who stated the importance of completing additional, ‘non-essential’ work to improve their chances of being successful when applying for the next stage of their training programme, since it is not a run-through training programme, unlike general practice and paediatrics. For example, one female anaesthetist trainee in her first year of training said:

“With going to things like conferences, it’s more for brownie points and improving your point score. So if I was applying for a job which is really
Given all respondents state they conduct some form of additional work in their own personal time, on a practical level it could be argued that the interview data suggests there are a number of potential problems with the current study leave system, particularly for hospital-based specialty trainees. Firstly, it can be seen that the current system for requesting study leave is not being implemented by specialty trainees due to respondents feeling that requesting study leave is too time consuming, or likely to cause an inconvenience to those responsible for approving it:

“Nobody does [apply for study leave] because it’s far too much hassle. So if a course or something falls on your off day, you just go and do it rather than arrange another day of study leave because you’re only likely to annoy people and plus there isn’t enough time” (Female paediatrics trainee, Interview 1).

Secondly, the interview data shows that there appears to be a perception amongst specialty trainees that they are expected to complete the additional work in their own time since they are not actively encouraged to complete additional work during their paid, clinical working hours. There may also be a view amongst senior consultants that specialty trainees should work longer shift patterns similarly to what they did before the introduction of the WTR to the NHS in 2004. This argument is explored further in the next chapter based on interviews with consultant anaesthetists and paediatricians. Another reason that emerged from the interviews for trainees to work over their already lengthy working hours is the time it takes to commute to certain hospitals for the hospital-based specialty trainees. As mentioned earlier, specialty trainees from anaesthetics and paediatrics are required to rotate their place of work every six months. In a large geographic area, such as the area used for this research, this means specialty trainees can be commuting over an hour each way to get to work, essentially adding additional working time to their day. In some cases, respondents rented in the location of their hospital rotation to reduce commuting time. However, this was reported to still have a detrimental effect on balancing work and personal life.
“I was working in [location] January until August which is quite a long way away, and I was renting a room up there so that has an impact on your work life balance because you’re not at home. So that was frustrating. That was quite an odd experience. I’ve been in my own home for eight years. So having to rent, and having a landlord and living miles away from home, not seeing your friends or partner or family.” (Female paediatrics trainee, interview 1).

Again, this is problematic for specialty trainees who have childcare responsibilities, most of whom are women. This can be seen in the previous findings chapter as to why many women are attracted to specialise in general practice due to the ability to remain in the same place of work for the vast majority of their training programme. Although there are training benefits to specialty trainees of gaining experience in different type of hospitals, on a practical level the HEE region also needs to ensure that a sufficient number of specialty trainees are working in each hospital within the region. This is particularly problematic for those responsible for workforce and rota planning in the geographic area in this research, such as the Training Programme Directors, since it is well known that most specialty trainees live in close proximity to the major city in this large geographic region:

“The main work life balance issue in paediatrics is where we send trainees...the region we’re placing trainees in...there can be very long commutes and that’s when trainees start complaining. A lot say, I’m driving two hours to [location] everyday and I don’t get home until half past 7 and my children have gone to bed already...that’s when work life balance starts becoming a problem...a disproportionate number of trainees live in [location] so that becomes difficult to accommodate” (Male paediatrics Training Programme Director, interview 48).

The issues surrounding rota planning relates to the next challenge for specialty trainees seen from the interview data, since the majority of respondents comment on the negative implications caused by hospital rota and GP appointment planning. These negative implications are discussed further in the next section.

HOSPITAL ROTA AND GP APPOINTMENT PLANNING
The second thematic code to emerge from the theme: managing and navigating working time, is hospital rota and GP appointment planning. In this section, hospital
based respondents are discussed separately to respondents based in GP practices. Hospital-based specialty trainees work rotas encompassing all days and hours of the week, whereas GP trainees tend to work Monday to Friday between set daytime only hours for the majority of their training within a GP Practice. The hospital-based specialty trainees mainly face challenges around the intensity of sequential rotas and planning annual leave, while GP trainees face challenges around intensity of their working day caused in part by the introduction of shorter appointment times.

Respondents from anaesthetics and paediatrics comment that the way rotas are planned can create periods of working time that are detrimental to balancing work life and private life. Many hospital-based respondents comment that the style of rota planning whereby there are numerous, continuous days of long, unsocial working hours, followed by time off work, is commonplace. One anaesthetics trainee comments that her weekly working hours are exceptionally long when working at the weekend as well as during the week.

“If I’m working weekends I will do my normal Monday to Friday 8am until 5pm, sometimes it drags out ‘til 6pm. Then I do Saturday and Sunday of 12noon til 12 midnight, and then hopefully have the Monday and Tuesday off.” (Female anaesthetics trainee, interview 7).

Therefore working hours during some weeks can be extremely intense and over the scheduled 48 hour week for full-time specialty trainees. However, due to the following week schedule of less than 48 hours, the average scheduled working hours over 17 weeks still conforms to the WTR (1998). Many trainees commented that this style of rota planning is detrimental to work life balance during the weeks where rotas are busier:

“In this job there are some really horrible shifts, so we do a seven day twilight shift where we work Monday to Sunday 4.30pm till 1.30am for seven days, and then come back to do normal shifts, Tuesday to Friday so that’s rubbish. That works out at 63 hours. But there’s other shifts where we do Monday to Friday 10am ‘til 8pm, so that’s 50 hours...and then Saturday and Sunday is 9am-5pm so that’s eight hours so that’s 66 hours in total. Then Monday, Tuesday normal days, then Wednesday and Thursday are 13-hour shifts then a normal day on
Friday. So out of 12 days in a row you’re looking at over 100 hours in those 12 days but then you have other weeks like this week and I’m not working at all. So it goes like that, you have periods of high intensity and then weeks of not and I think they do that purposefully. Partly for continuity, then when you have time without the on-calls and everything that’s a good time to ask for your annual leave.” (Female paediatrics trainee, interview 1).

Hospital-based respondents reported that they are expected to take annual leave during quieter periods where they are not scheduled to work weekends. Rotas are often planned with this as the main aim. Therefore specialty trainees often have fixed annual leave on their rotas and it is expected that specialty trainees rearrange their rotas if they would like to take annual leave on days outside their designated fixed leave. However it is not always realistic that hospital-based specialty trainees will be able to take annual leave during the time scheduled by the rota planner. Therefore, respondents stated that swapping shifts in turn often creates more intense working weeks for themselves:

“There’s only four of us on the rota and you have to take into account leave. Our rota master is pretty good that if we want leave that we can get it if we can get someone to swap for us. So sometimes I end up with really horrendous 12 days in a row working just to pick up the slack for somebody else or if we’ve swapped it so we can go on leave...if it’s really bad it’s normally our own doing for needing to swap with someone.” (Female anaesthetics trainee, interview 7).

Interviews showed that this style of rota planning also creates further challenges for those with childcare responsibilities who may seek family compatible working times. For example, specialty trainees with children may want to align their own annual leave with their children’s school holidays. However, achieving this comes at the expense of their own and others’ reasonable working time patterns:

“I think fixed annual leave is really unfair, it’s really mean in terms of work life balance. Especially if you have kids and want half term off or whatever ...Often swapping, when you have days that are really on-call heavy, then quieter days when you can have annual leave often if you want to swap to take holiday on the days when you’re really on-call heavy. Then more often than not the person you’re swapping with is then putting themselves in a really bad situation because it may mean the other person has to do two weekends in a row so
you’re making their lives a bit miserable.” (Female paediatrics trainee, interview 1).

Interview data shows that general practice trainees experience different challenges relating to working time compared to hospital based trainees. GP trainees are required to work unsocial hours for at least six months of their three-year training programme whilst they complete a hospital-based placement. During the two and a half years GP trainees are working in the GP practice, working hours are usually Monday to Friday between the hours of 8am and 6.30pm. However, we know from the previous section that due to additional work these hours are inevitably longer. The new, shorter ten-minute appointments, combined with a context where the specialty is understaffed, as mentioned earlier, creates increasing pressure on GP trainees’ working time:

“You’ve only got ten minutes with a patient and that’s not long enough, and in an emergency clinic you only have seven minutes with a patient so that’s quite a time pressure...it’s the time pressure of how long you can see patients. It’s understaffed and you have to pick up other peoples’ work and everyone is quite stressed out” (Female GP, interview 30).

It can be seen from the interviews with trainee GPs that they were not expecting the work pressures caused by more, shorter appointments and understaffing to be as intense as it is in reality: “I thought the work life balance was going to be good but it’s not” (Male GP trainee, interview 17). This finding was the same for both male and female GP trainees.

**Less Than Full Time (LTFT) Training**

The complexities surrounding working time mentioned in the previous two codes show that full-time working hours in medicine are not compatible with family life. This is confirmed by the fact that all LTFT trainee respondents reduced their working hours for childcare reasons. The interview data highlights several challenges LTFT trainees face when planning and managing reduced working hours. The components of LTFT training are outlined again here as they set the context that specialty trainees are managing their working time within.
Working time for LTFT specialty trainees is calculated as a percentage of full-time employees’ hours. In anaesthetics and paediatrics, specialty trainees are encouraged to job share with another LTFT specialty trainee and work 60% of full-time hours, working 50% of the on-call rota. However, some trainee anaesthetists and paediatricians may be able to negotiate working 80% of the rota with their Training Programme Director from their HEE region. There appears to be more flexibility for GP trainees, with the percentage of work completed the choice of the trainee, apart from the trainee is required to work 50% or more of full-time hours. However working time arrangements are dependent on the GP practice and arranged at practice level. Although the connotations of working LTFT lie with the premise of working part-time hours, it should be noted that LTFT specialty trainees’ weekly working hours are not much below full-time hours particularly if work outside contracted hours is included. For example, if a specialty trainee is to work 80% of standard working hours and 50% of on calls, they are still scheduled to work approximately 36 hours per week, not including additional non-paid working hours.

There are eligibility criteria a trainee must meet to apply for LTFT training. These criteria have been ranked in terms of importance by the employer and have been split into two categories, with category one applicants treated as ‘priority’. Category One criteria are: disability or ill health (this may include IVF programmes), responsibility for caring for children, responsibility for caring for ill or disabled partner, relative or dependent. Category two consists of reasons surrounding further study for courses outside of specialty trainees’ medical training programme (NHS Employers, 2017). Even though the option to work less than full time is available, there are still fairly strict criteria to meet.

The interviews show that most respondents opting for LTFT training are women once they return to work after their maternity leave. Three of the male respondents also worked LTFT, all of whom specialised in anaesthetics and had childcare responsibilities. These three male respondents chose to work LTFT to share childcare responsibilities with their female partners whom also worked part-time hours within professions with long full-time working hours, such as medicine and veterinary medicine. The LTFT
respondents commented on the challenges they face. Firstly, LTFT trainee respondents reported a lack of flexibility with their LTFT working arrangements. A number of specialty trainees noted that the percentage of full-time hours LTFT trainees have to work are inflexible, despite these trainees opting to work LTFT to improve the management of their working time and personal life. The current organisation of LTFT working hours arguably suits the needs of the employer by ensuring gaps in the rota are filled in the most cost-effective way, whilst also meeting the training needs set out by the Health Education region.

“It doesn’t really work if you want to do 80% or even less than 60% doesn’t work either. So I think you’re discriminated in that sense because if it doesn’t work around the rota, you’re not allowed to say how much you want to work.” (Female paediatrics trainee, interview 19).

This lack of flexibility calculated as a percentage of full-time working hours causes several issues for LTFT, and prospective LTFT, specialty trainees. Interviews show that working just 60% of full-time hours has negative financial implications for most specialty trainees who may want to work more hours but are unable to do so. An interview conducted with an official from the BMA confirms that LTFT specialty trainees have frustrations about the rigidness of the percentage of hours they are able to work, and the gendered implications this can have on women who are more likely to work LTFT:

So you’re told you’re it’s a choice of 60% or nothing and you have to find somebody to share to do the other half with. We’ve got plenty of examples of doctors saying ‘this is ridiculous, I could work more hours’...they’re like ‘if there was more flexibility with the LTFT options I could actually put in more hours for the NHS’. Everyone was quite excited about an emergency medicine pilot recently...they were talking about offering 80% and we had tons of LTFT trainees leaping on that. It just shows if you can get 80% in emergency medicine surely you can get 80% in other specialties and surely there’s more flexibility...I heard one story of a couple who had just had a child and they were both doctors and they both wanted to go back 80% and they were told: ‘no it’s 100% or 60%’, so he does 100% and she does 60% so her career is permanently scarred (BMA official, interview 45).
In addition, the interviews show LTFT trainees actually work over their scheduled reduced hours for no extra pay, regardless of being set the strict 60% amount of full-time hours. Again, this was more problematic in paediatrics since 60% of the full-time equivalent working hours are seen as too little for the amount of work to be completed. The interview data shows that working LTFT hours also causes gendered negative implications towards male specialty trainees, since a number of male respondents, and respondents’ male partners, have been refused LTFT working hours because of the shortage of doctors on the rota, so female specialty trainees were given first priority of working LTFT:

“I asked for a reduction in my working hours and I wasn’t allowed because there are not enough people to fill the rota” (Male paediatrics trainee, interview 6).

This view that men are expected to work full-time was a common theme from the interviews with trainee paediatricians, with many saying male trainee paediatricians are seen as “gold dust” (female paediatrics trainee, interview 1) and are encouraged to stay within the specialty as they are much less likely to work LTFT. Similarly, the Training Programme Director for anaesthetics said that male trainees, whom are usually full-time, are less likely to be able to work at a hospital location close to their home as LTFT trainees, whom are usually women, are more likely to be able to influence where their hospital rotation will take place:

“There are some niggles from the trainees because the LTFT trainees tend to get placed a lot more according to where they live...So if you’re not a female LTFT you’re more likely to be sent [further away from where most trainees live]” (Anaesthetics TPD, interview 40).

Therefore, the interviews support that there is an assumption within the organisation that female specialty trainees will work LTFT to accommodate childcare arrangements, thus creating gendered outcomes for both male and female specialty trainees whereby

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13 A report by the RCPCH (2017), released during this research, shows that workforce pressures are increasing in paediatrics. These pressures are due to a combination of reasons, including staff shortages, higher workloads and inadequate funding. The report also predicts that staff shortages in paediatrics will be exacerbated in the near future as fewer foundation doctors plan to specialise in paediatrics.
men are denied reduced working hours and expected to commute further, and women are expected to work LTFT based on their gender.

SECTION TWO: MANAGING AND NAVIGATING CAREERS

Introduction

The next theme that arose across the interviews was how specialty trainees manage and navigate through their careers. Specialty training is a pivotal period of the medical career, since successfully completing specialty training is vital in order to achieve a future consultant or salaried GP/GP Partnership post. It is clear from the interview data that specialty trainees faced numerous challenges when managing and navigating through their medical careers during specialty training. These challenges stem from the context of the medical profession, such as long training programmes, high amount of geographical mobility, and competition to enter the next stages of training. Again, similarly to issues around working time, the majority of female respondents feel that the challenges of managing and navigating through their careers become heightened when combined with planning a family.

The interview data shows that once specialty trainees are working within their chosen specialty, the way they navigate and manage their careers is strongly influenced by the structure and nature of the training programme they have chosen. In addition, it is evident that female respondents' decision-making around beginning a family is also strongly influenced by training programme structures. It is known from the previous chapters that each specialty-training programme involved in this research is unique and involves its own complexities. Due to the diverse nature of each medical specialty, and for ease of reference, each specialty's key training structure characteristics are discussed briefly in turn before presenting the challenges they create for specialty trainees, particularly women.
*Anaesthetics*

The interview data shows that characteristics of the anaesthetics training programme create a complex context that anaesthetist trainees navigate through. Anaesthetics is the only specialty included in this research that is not a run-through training programme, so specialty trainees are required to re-apply after two years of basic core training to the next stage of their training programme. This can be to train in general anaesthetics or to the ACCS programme. The latter option adds an additional 18 months to the training programme whereby trainees can then specialise in intensive care medicine alongside completing the broader anaesthetics training. Competition is high for the ACCS training programme as there are fewer training numbers and it is also a popular choice amongst anaesthetists. Full-time, the anaesthetics training programme is one of the longer duration programmes and takes between seven to eight and a half years to complete, depending whether the ACCS route taken. Due to training taking place in hospital, specialty trainees are required to rotate their place of work every six months.

*General Practice*

General practice is a much shorter training programme, compared to the other medical specialties, and takes three years to complete full-time. It is a run-through training programme so once specialty trainees have successfully gained a training number to begin the training programme, they do not need to re-apply to advance to the next stages of their training. General practice trainees spend the majority of their training in one fixed GP practice, usually determined by the trainee themselves to be close to home. Trainees are required to spend six months within a hospital-based specialty to gain additional skills. It is during this six months that working time includes more unsocial working hours during nights and weekends.

*Paediatrics*

Paediatrics is one of the longest medical training programmes, taking eight years to complete full-time. Similarly to general practice, paediatrics is also a run-through training programme, so trainees apply once to begin training and keep their training number throughout the duration of their training programme. Paediatrics trainees are
required to change hospital every six months. However they are often placed at the region’s children’s hospital to gain more exposure to certain medical conditions. At the end of their fifth training year, paediatrics trainees are given the option to apply to sub-specialties within an area of paediatrics. This is referred to as GRID training, and is highly competitive as there are a limited number of places within each sub-specialty and often involves a geographical move.

**MANAGING MEDICAL CAREERS AND PLANNING FOR A FAMILY**

In a feminising workforce it can be expected that issues around managing pregnancy, maternity leave and parenting at work are going to become more and more prevalent, and this expectation is confirmed as a common theme across the interview data. Seven of the eighteen female specialty trainees interviewed were mothers (anaesthetics = 1, general practice = 2, paediatrics = 4), and it appears that these mothers had differing experiences of managing and navigating through the stages of having children. In addition, interview data shows that female specialty trainee respondents who were not mothers also commented on how they plan to manage starting a family whilst in specialty training. Therefore it can be seen that the structures and attributes of training programmes structures become a shaper of specific gendered strategies for managing careers and family.

This section focuses on each stage of motherhood chronologically, according to the themes that have emerged from the data. This section begins by looking at how women may attempt to plan when to have a baby around their training programme. Next the issues surrounding specialty trainee mothers managing their pregnancy at work are discussed, and finally the logistics surrounding female trainees’ return to work and organising childcare after maternity leave are presented.

The interview data shows that female specialty trainees attempt to plan when to have children around their training programme. Respondents state the main reason for this is to achieve prolonged job security whilst starting a family, since good maternity pay is guaranteed and it also allows for children to be close to, or of, school age before specialty trainees reach their destination job as a consultant, salaried GP or GP.
Partner. The interview data shows that women tend to plan to have children according to the length of their training programme and/or to align having children after key points of the training programme timelines. For example, planning to have children once examinations are over:

“I made sure I got my exams out of the way. I consciously did that before I had children” (Female paediatrics trainee, interview 19).

The interview data also showed that women often planned to start a family towards the end of their training programme, so if they decide to return to work as a LTFT trainee, they have fewer years left of their training programme to complete over a prolonged period of time. Interviews with women specialising in paediatrics showed that these respondents aim to plan to have children towards the end of their training programme for these reasons highlighted above.

“I’m ST7 now, and that position ends in February next year, then I’ve got ST8 to do part-time and the aim is to get pregnant again in August to have another baby in May, so the way I’m timing it, it works out with rotas and shifts and things. Hopefully I can prolong training a bit longer until I have another baby and then go back part-time for a bit when I have a bit of training left. So hopefully I’ll spread it out another three and a half years.” (Female paediatrics trainee, interview 20).

Although general practice is a much shorter training programme, interview data shows that the majority of female general practice trainees plan to have children towards the end of their second or early in the third year of their training programme. Many female general practice trainees commented that this was to improve their chances of gaining a salaried GP post after training since it could be perceived at the future interview stage that their family was complete and they would not take time off in the near future to have children.

Even though employers shouldn’t discriminate against a being female around 28 [years old], you know aged around that sort of period, they shouldn’t discriminate and think ‘oh she might go off and have a child’ but it does happen and that’s a bit of a worry really. Really you should have your children whilst you’re on the training programme so that you’re still on the training
programme, you’re still getting your maternity pay and then you just return back into the programme and then maybe go part time, so that’s the best plan really if you can...but you have to sort of think of these things because once you are qualified as a GP, like I said, it shouldn’t happen but you can get discriminated against being a female of a certain age – you might not be as employable unfortunately, it shouldn’t happen but it does unfortunately. (Female GP trainee, interview 30).

This quote also highlights issues surrounding the age of specialty trainees whilst they are in training coinciding with a time in their lives when they plan to have children. Many respondents said they had purposefully planned to have children later than if they were in another job role in order to complete as much of their training programme as they could. This was particularly the case for anaesthetics and paediatrics trainees. Male specialty trainees who were in a dual doctor relationship also expressed this view:

“I’m 30 now...I would’ve had kids already if I wasn’t a medic” (Male anaesthetics trainee, interview 9).

However, the TPD for paediatrics commented that the run-through style of training programme has helped women to have children earlier in their careers compared to the past when specialty trainees were required to reapply for each training post, despite specialty trainees interviewed saying they planned to have their children after their main examinations:

“When I qualified, in the beginning of your training you were constantly reapplying for jobs and I think that meant for women in particular that they wouldn’t have children during that time of their training. So they would wait until they were in a position where they were relatively settled...when we introduced run-through training, about 10 years ago, what we felt might happen is people might feel more comfortable earlier on...so they’ll be starting training and they’ll know where they are for the next eight years so what’s tending to happen is people are going off on maternity leave at a much earlier stage than they were say 20 years ago. Before I’d say hardly anyone went on maternity leave in the early stages of their careers...whereas now people...will go off on maternity leave during their first year of training” (Paediatrics TPD, interview 48).
It can be seen that across all of the specialties that training programme structures are key in shaping the life decisions of specialty trainees, particularly for women starting a family. Next, the experiences of specialty trainees whilst they are pregnant are discussed.

*Managing pregnancy at work*

The previous theme on working time shows that specialty trainees would require support during pregnancy given the extremely long, and often unsocial, working hours. Also, staff shortages, intense working hours, combined with inconsistent line management due to changing workplace, and consequently changing educational supervisor, every six months creates a context whereby mother respondents showed a good level of support is often not possible and trainees are left to sort out their own arrangements. The distant HR function adds to these challenges, since the vast majority of respondents stated that they rarely approach HR and would not know whom to contact.

Specialty trainee mother respondents had mixed attitudes towards how well they were supported whilst pregnant at work. Mothers specialising in hospital-based specialties commented more on the issues surrounding when they were able to come off working nights (on-call) and it is evident that discrepancies exist across hospitals in terms of when pregnant trainees can officially come off the on-call rota. For example, one paediatrics trainee commented on how she was able to come off the on-call rota when she was seven months pregnant, whereas another paediatrics trainee was not able to come off the on-call rota until she was eight months pregnant, despite feeling ready to stop earlier. Therefore hospital-based specialty trainees’ experiences during pregnancy varied depending on what hospital they were based at and but also how vocal they were about the support they required. One paediatrics trainee mother describes:

"After eight months I’m coming off on-calls but I had to push for that myself and even now I feel like now, if I’m being really, really honest, I’d like to come off on-calls now. (Female paediatrics trainee, interview 19)."
Respondent mothers also shared feelings of a lack of support during their pregnancy due to the NHS being under-staffed. This meant specialty trainees from the hospital-based specialties felt there is the expectation to carry on with work because, if not they were “making things difficult” (Female anaesthetics trainee, interview 16).

Hospital-based trainee mothers also felt guilty about leaving gaps in the rota if they were to ask to reduce their working hours and/or stop working nights during the later stages of pregnancy due to the strain it would put on their colleagues in an understaffed workforce:

> “Like today, for example, I’m working 9am until midnight and that is hard when you’re heavily pregnant...I would’ve loved to wind down on the rotas but I know the rota’s short and at the same time you don’t want to make someone else’s life more difficult because it’s your colleagues that pick up the slack. So yeah, I don’t think they really do much concessions or support you through pregnancy” (Female paediatrics trainee, Interview 19).

Although the HR policies in place state that pregnant trainees should have a risk assessment, phased return to work and also up to ten fully paid ‘keeping in touch’ (KIT) days prior to returning to work after maternity leave, the majority of specialty trainee mothers interviewed stated that these initiatives were not enacted upon and, if they were, they were completed to ‘tick-box’ a requirement rather than to provide meaningful support. In addition, there is a common view amongst the specialty trainees interviewed of “getting on with it” whenever they experience any negative aspects of their working life. This finding is also confirmed by one of the BMA officials interviewed who said:

> “You hear it time and time again of just get your head down and get through it and move onto the next placement and hope that it’s better” (BMA official, interview 45).

This might explain why the TPD respondents, who are responsible for allocating trainees to their hospital rotations, did not mention any incidences of pregnant trainees reporting negative experiences such as being refused requests to come off the on-call rota or of not feeling able to ask to come off the on-call rota. The next section
mainly focuses on these tensions between the maternity policies in place and how they are utilised in practice, thus creating gendered outcomes.

**Managing returning to work after maternity leave**

As discussed, specialty trainees within anaesthetics and paediatrics are required to rotate hospital location within their HEE region every six months. Therefore it could potentially be the case that when trainees return to work after maternity leave that they are assigned to a new hospital rotation, potentially working in a hospital where they have not previously worked. This may be extremely daunting, particularly if a trainee has had the maximum maternity leave of 52 weeks away from practising medicine. The vast majority of the mothers interviewed felt they had to strongly stipulate to their educational supervisor that they wanted to return to a hospital of their choice, ideally one close to their home and where they had worked before. The most common reasons were the shorter commute, familiarity with the staff and knowledge of the layout of the hospital. A paediatrics trainee mother said she had to plan her working days well in advance and be assertive about the hospitals she was prepared to work in once she returned to work after her maternity leave.

“I purposefully asked to go back to a place where I’d worked before. I think if I had gone back to somewhere where I hadn’t worked before, I would have found that really difficult but people knew who I was, the nurses know me, the consultants know me as well...Basically I had to email the guy who decides where everybody goes, and I said please send me somewhere where I’ve been before and I gave him a list of four hospitals” (Female paediatrics trainee, interview 20).

Similar to the expectation that trainees will organise their rotas to enable the taking of annual leave, this quote reveals that specialty trainees are expected to organise their return to work in relations to the hospital they are placed at. There appear to be complexities and uncertainties around who is ultimately responsible for organising a specialty trainee mother’s return to work after maternity leave. From the interview data it appears that these uncertainties around responsibility lie with both the specialty trainee, and also educational supervisors and TPDs. Very few specialty trainees, of both genders, commented that they referred directly to Human Resources
for employment related issues, and this applied similarly to specialty trainee mothers and their pregnancy and maternity leave. As highlighted above in the quote above (interview 20), specialty trainees’ first port of call is usually their educational supervisor, or TPD. However, specialty trainee mothers interviewed who wished to return to work LTFT commented on how they were expected to organise their own job shares with another LTFT specialty trainee. This may be because educational supervisors and TPDs are “also working as a doctor so the time to deal with these things are kind of limited” (Female GP trainee, interview 2) in terms of placing and organising specialty trainees’ working hours. Or perhaps it could be that there are no structures in place to organise job shares for specialty trainees. This appeared to be a common issue amongst the interviewed paediatrics trainee mothers, who commented on how they were expected to plan their own job shares when they returned to work LTFT following maternity leave:

“I think from a planning point of view I gave them enough notice, but he [TPD] still came back to me and said ‘okay but you need to find somebody to job share with’ and I was like ‘err no that’s your job’ so then he did actually come back and find somebody to job share with and it’s worked out really well…but I think that was more luck than anything anybody actually did” (Female paediatrics trainee, interview 20).

Similarly another paediatrics trainee reported “going part time isn’t very easy because you have to find a job share and…trainees in paediatrics tend to have to decide amongst themselves, usually via Facebook or email!” (Female paediatrics trainee, Interview 23). Again, this quote highlights two issues. Firstly, that there is a high level of assertiveness and persistence required by specialty trainee mothers to stipulate the terms of their return to work after maternity. This scenario with another trainee who may not have been as confident to say “no” to organising their own job share could possibly have very different, and quite possibly cause more detrimental outcomes for the specialty trainee. Secondly, there is an issue around why TPDs may be unable to organise job shares themselves, particularly in the highly female-dominated specialty of paediatrics. The interview with the TPD from paediatrics highlights the difficulties of arranging where LTFT trainees are based, often women post-maternity leave, and that is a multifaceted and complicated issue. Firstly, there are a high proportion of specialty
trainees who work LTFT within paediatrics. In the HEE region studied, the paediatrics TPD reported almost a third of paediatrics trainees work LTFT partly due to higher numbers of women within the specialty who work LTFT for childcare reasons. In addition, the TPD for paediatrics comments that largely due to the run-through organisation of the training programme, paediatrics specialty trainees can switch from full-time to LTFT, and vice versa, repeatedly throughout the duration of their training programme, which adds to the complexities of arranging rotas.

Secondly, for paediatrics there are issues surrounding the amount of notice TPDs are required to give the hospitals regarding the number of specialty trainees available that can fill their rotas so hospitals have sufficient time to hire SAS grades and/or locums to fill any upcoming rota gaps. The notice required is usually three to six months in advance. Therefore, if a specialty trainee requests a certain hospital location after this notice has been given by the TPD, it is likely that the rotas for that hospital have been filled so a LTFT is consequently unable to work there.

Thirdly, the time of year when a specialty trainee returns to work after maternity on a LTFT basis has an impact on which hospital they are placed at. The TPD for paediatrics comments that it is easier to arrange hospital locations for LTFT trainees when they return to work at the beginning of a new hospital rotation:

“often people will try and come back at the changeover, so everything changes every six months in February and August but sometimes for whatever reason people say ‘actually I want to come back in June’. If you come back in June and we’re changing over in August and you’re only working three days a week, then you’re only doing three to four weeks full-time equivalent in the same place. So it’s unsatisfactory to move someone after that. So it’s about trying to put someone in a place where they will also be working after changeover, as much as possible and sometimes it isn’t possible” (Paediatrics TPD, interview 48).

In addition, there also appears to be difficulties arranging LTFT trainees’ hospital locations because “there’s been lots of cuts to HEE, and there’s all sorts of problems at the moment with making sure there’s adequate notification in terms of notification of
placements and working hours...especially with the lack of staff at HEE these days”  
(BMA official, interview 45).

The interview data shows mixed opinions across all three medical specialties regarding whether specialty trainee mothers are well supported once they return to work. As briefly mentioned earlier, the majority of specialty trainee respondents commented on the need to “just get on with it” when at work. This mostly stems from the lack of resources and staff available to feel comfortable with asking for support. This view was the also same with the majority of mothers interviewed. One general practice specialty trainee sums up this issue when asked whether she feels specialty trainees are well supported when they return to work after maternity leave:

“No I don’t think anyone going through anything is very well supported. I think you’re just expected to get on with it and people just do really...I think other doctors treat you quite well but in terms of support there’s nothing extra”  
(Female GP trainee, interview 2).

Similarly one paediatrics trainee mother when asked if she felt supported when she returned to work after her first child, replied:

“I just found it really quite hard, at least for the first few shifts, getting back into it. You have your confidence knocked if you’ve been out of something for a while, especially with practical procedures...I don’t think people understand, when handover was over, they didn’t understand that I might have got back into my car and cried my eyes out because it meant I didn’t get to see my child before bedtime. That just wouldn’t have been on their radar, things like that”  
(Female paediatrics trainee, interview 19).

Drawing from the interviews with specialty trainee mothers, it does appear that the experiences they have are very much dependent on their familiarity with the hospital they are assigned to when they return to work and how vocal they are about the support they need. It was also surprising to hear that the level of support varied quite considerably even though trainees were working within the same specialty. For example, as seen in the responses above, one paediatrician was able to negotiate to come off the on-call rota at 28 weeks (seven months) pregnant at one hospital,
whereas the other, at a different hospital, was told she had to work on the on-call rota until she was eight months pregnant.

**Managing Childcare**

Managing childcare alongside specialty training was a challenge for specialty trainee parents, particularly mothers with many choosing to return to work LTFT to look after children, as seen previously. The interview data provides evidence of mothers having to be stricter with their working time so they tended not to be able to stay late after their scheduled working hours as often as specialty trainees without children due to having to pick their children up from childcare. In addition, interview data shows that specialty trainees felt the proposed changes to the junior doctors’ contract of increasing unsocial working hours could cause difficulties around accessing childcare. It could be argued that the nature of doctors’ working time is inherently unpredictable and unsocial. However the proposed junior doctors’ contract at the time of data collection, anticipates the number of unsocial hours to rise. This would result, therefore, in an increase of working hours when it is more difficult to access childcare, particularly if specialty trainees do not have access to family and friends to help with the burden of childcare.

When proposing the new contracts, the state acted in a way that assumed that specialty trainees had access to family and friends to help with accommodating childcare. However, this is not always the case. A female anaesthetics trainee comments on the negative implications of the original proposed contract during the time of interviewing:

“*When you look at the new contracts and the number of weekends we’ll be doing, I just kind of think ‘how will we do this? There won’t be enough nurseries open at that stage’...Especially if you’re both training to be doctors, you’re going to need cover for like three weekends out of four for looking after a child... There’s very little childcare support so people have to rely very, very heavily on family and friends bailing them out*” (Female anaesthetics trainee, Interview 12).
This quote highlights that the proposed contract created negative gendered outcomes caused by the actions of the state. Firstly, the state assumed the gendered roles within the household, in the sense that there will be two parents sharing the childcare responsibilities. Secondly, if specialty trainees do not have a partner or family to help with childcare, they are more likely to have to work LTFT and be penalised. As discussed in more detail below, there is strong evidence that LTFT trainees will be negatively impacted by the new junior doctors’ contract in terms of their pay progression, and the implied changes in working hours may make it more likely that female trainees will opt to work LTFT. Thus, as a consequence, female specialty trainees are more likely to be negatively affected by the impact the proposed contract had on childcare arrangements.

SECTION THREE: GENDER PAY GAP AND THE STATUS OF THE MEDICAL PROFESSION

Changes to the junior doctors’ contract – documentary analysis

The third main theme that arises from the interview data concerns how the recent feminisation of the medical profession influences issues surrounding pay equality and attitudes towards the status of the profession. It can be seen from the interviews that both are perceived as changing. The main findings surrounding pay emerge from interviewees’ responses in terms of the government’s changes to the junior doctors’ contract. The first is that female specialty trainees felt they would see their pay decreased under the proposed contracts since part-time trainees’ pay increments would progress at a slower rate than each year. Secondly, because of this, interviewees also felt that the gender pay gap would thus widen once the new contract was implemented. In addition, there were also concerns surrounding increased unsocial hours work for less remuneration.
This section begins with documentary analysis of DDRB, DH and BMA reports during the contractual negotiations. As indicated in the context chapter, at the time of the interviews, all specialty trainees had access to annual pay increments, regardless of their full-time or LTFT status and regardless of whether they were in work or on leave (including maternity leave, and research leave). However, also at the time of the interviews\textsuperscript{14}, the DH proposed changes to specialty trainees’ employment contracts, based on the recommendations of the DDRB’s report in July 2015 that were chaired by Professor Paul Curran. Following the report, the state aimed to change from automatic annual pay progression to a system where the increase in specialty trainees’ pay depended upon successfully reaching the next year of their training programme. At the same time, the state also proposed to reduce the amount of hours classified as ‘unsocial’ when specialty trainees can earn a higher rate of pay, whilst at the same time increasing the number of unsocial hours working.

Prior to the proposed changes to the contracts, as well as the basic salary paid to full-time and part-time specialty trainees and that increased automatically every year worked over nine pay increments specialty trainees also received non-pensionable banding supplements ranging from 20%-100% of their basic pay for each of their training posts, depending on the number of hours worked and intensity of the working patterns. GP specialty trainees were also in receipt of a banding supplement set at 45% of their basic salary introduced partly as an incentive to attract doctors to specialise in general practice.

Under the new system of pay progression proposed by the Department of Health basic pay would increase by around 11% and the number of increments, now labeled nodal points would decrease (initially unspecified) with access dependent on successful progression to the next training level, rather than years in service that defined specialty trainees’ pay progression under the existing contract. This basic pay would cover 40 hours of work per week. The government’s argument for this change was that

\textsuperscript{14} Interviews with specialty trainees were conducted between February and May 2016. Therefore the initial changes to the contract were proposed during this time and the current imposed contract was unknown.
pay would be determined by ‘achievement of excellence’ and increased responsibility, instead of years in service. The DDRB report suggested that pay progression should be decided via an appraisal, and the body emphasised the importance of appraisers being properly supported to avoid discrepancies between geographical areas and specialties. The Association of Anaesthetics said the appraisal-based pay system could allow for “rogue trusts” to suspend doctors’ progression in order to reduce their salary bill. It could be argued that this type of pay progression has a detrimental effect on women as they are more likely to take time out of training to have a baby, so they will stay on the same salary throughout their time off and when they return to work. Also, specialty trainees who work LTFT would not receive their pay increment as quickly as full-time trainees because it would take longer for LTFT trainees to progress to their next stage of training. Again, this change would be more likely to negatively impact female doctors, since female doctors are more likely to work LTFT. This is a view that the British Medical Association and Medical Women’s Federation both highlighted in their evidence to the DDRB prior to the body’s initial pay recommendations. However the DDRB argued, “provisions that affected individuals differently were reasonably necessary to achieve business objectives” (DDRB, 2015, page 25).

The initial proposals to assess pay progression also meant that doctors who wished to change the specialty they were training towards would experience a decline in pay, as they would effectively be starting their training, and consequently salary, from the beginning, despite having several years more experience. Again, this would arguably have a more detrimental impact on women, since they are more likely to drop out of a specialty in order to change to a specialty that offers more flexibility and family-friendly working hours once they have a baby. For example, it is found that female doctors often drop out of hospital specialties and opt for general practice as it is perceived as a specialty which has working hours to accommodate family-life and an improved work life balance (Goldacre et al, 2001).

Another initial proposed change to the pay structure was to shorten the period of working hours that are defined as ‘unsocial’. Banding would be abolished and extra payments would be made for ‘rostered hours’, namely those additional to the basic 40
hours limited to eight additional working hours on average per week. Furthermore payment for unsocial hours was set to change: under the prevailing junior doctors’ contract, ‘unsocial’ working hours were defined as 7pm to 7am, Monday to Friday and all day on Saturday and Sunday. The initial proposal was to change the definition of unsocial working hours for junior doctors to 10pm to 7am, Monday to Saturday and all day Sunday. This change would have a detrimental effect on those working in specialties where unsocial working hours are more commonplace. These changes would mean those trainees in specialties, such as A&E and paediatrics, would see a decline in their pay as they entail a higher amount of ‘unsocial’ working hours.

However, specialties, such as dermatology and pathology, would see less of a negative impact since there is little requirement to work during unsocial hours. Curran’s (DDRB, 2015, page ix) report for the DDRB argues “the proposed unsocial hours definitions are in line with practice in other sectors, and also in health services internationally”, and “the unsocial hours approach for the NHS should be designed around the service needs of the patients” (DDRB, 2015, page 14). Thus effectively the recommendations normalise unsocial working hours, for less pay, and are focused on the needs of the patient more so than the safety of doctors.

The way the definition of ‘unsocial’ working hours was investigated by the DDRB could also be said to have its flaws. The DDRB appointed the Income Data Services (IDS) to compare doctors’ current definition of ‘unsocial hours’ to other sectors in the UK and health services in other countries. The IDS suggested that the medical profession should be compared to airline pilots - who are also highly skilled, have completed many years of training and are responsible for peoples’ lives and safety. However, it could be argued that this comparison fails to consider that the vast majority of pilots are male. Therefore the definition of unsocial working hours that are reasonable for a man may be very different to that of a woman, since women still hold the majority of childcare and domestic responsibilities (Lyonette and Crompton, 2015). IDS also compared doctors’ unsocial working hours with other sectors such as retail and hospitality and suggested that unsocial working hours starting at 10pm would bring doctors in line with other sectors. Again, this comparison has its flaws, as it could be argued workers in retail are more likely to be working part-time, and work shorter
hours in total compared to doctors. Moreover, the additional unpaid hours specialty trainees work that are necessary to complete their training, as evidenced in section one of this chapter, are not considered when making comparisons with other sectors and occupations.

Prior to the proposed initial changes, general practice trainees received a 45% banding supplement for work during unsocial hours. Initially the government proposed that this supplement should be completely removed which if implemented would have had detrimental gender effects as there are a greater number of female GP trainees than male. However, probably due to the recruitment crisis, this proposal was soon withdrawn.

Following these initial proposed changes to the contracts, the BMA balloted and held industrial action that coincided with the period of data collection for the project. Some concessions were made including reversal of the withdrawal of the GP banding, reduction of nodal points to five, and expansion of non plain time to from 9pm Monday to Friday and 5pm Saturdays. No resolution was found and in February 2016 the government announced its intention to enforce the new contract but first it belatedly carried out an equality impact assessment. Although the equality analysis did find that female doctors were more likely to detrimentally suffer from the contract changes in the ways highlighted above, the state’s main outcome of the analysis was that the changes to the contract could be considered “a proportionate means of achieving a legitimate aim” (Department of Health, 2016a).

This statement raised concerns from the BMA who insisted that the outcome of the equality analysis should undergo judicial review and the Equality and Human Rights Commission (EHRC) indicated that the contract could breach the employers’ obligations under the Public Sector Equality Duty. This led the resumption of negotiations under ACAS, which resulted in an agreement to put a revised new contract to a vote of the BMA members. Several new concessions were agreed which in the preamble to the associated revised equality statement indicated that “a particular focus of the new terms was to enhance family friendly working in the
context of the government’s commitment to 7 day working” (Department of Health, 2016b). For example, basic working hours changed to 7am – 9pm Monday – Sunday but an additional allowance of up to 10% of annual salary if doctors work more than one in eight weekends full time, capped at a maximum of one in two weekends. This is pro rated for part-time doctors. Even though there was no U-turn on the annual pay increments, the BMA encouraged pay progression to be based on a four-point nodal pay scale with pay increases ‘frontloaded’ earlier in the career, with the view that female doctors can increase their salary more quickly before taking time out of employment to start a family. The option for trainees to receive ‘accelerated training’ support once they returned to work was also more openly encouraged following the second equality impact assessment, so women could progress to the next pay scale more quickly. The BMA also negotiated funding for a new ‘senior decision maker’s allowance’, due to come into effect in October 2019, which aims to increase pay further at the end of training when trainees have increased responsibility and knowledge. In addition to this, due to the BMAs negotiations, there is now also pay protection offered to doctors changing their medical specialty-training programme for caring and disability reasons. It should also be noted that the new junior doctors’ contract removes the external auditing of working hours through the compulsory employment of ‘guardians of safe working hours’ at each NHS Trust that trains over ten specialty trainees. Guardians of safe working hours must not hold any other role within the management structure of the employer or host organization, and are responsible for overseeing and reporting any breaches to specialty trainees’ maximum weekly working hours, as of the EWTD.

These negotiated revisions were put forward to a vote of BMA members. The result was 58% of the 37,000 BMA members who voted disagreed with the contract. However this version of the junior doctors’ contract was still implemented in October 2016 and remains far from ideal, particularly for female doctors. Firstly, the extent of how accelerated training will work in practice remains unclear and how much training can be accelerated is limited, especially if the female doctor returns to work part-time after starting a family. Secondly, although pay progression has been front-loaded to enable women to progress their pay before taking time out to start a family, those
taking maternity leave or switching to LTFT before reaching the maximum salary would take longer to progress. Furthermore the intention is to increase weekend working and the equality impact assessment failed to address the lack of childcare available to doctors at the weekends. In the first equality impact assessment it was explicitly assumed that partners, family, and friends can take on childcare responsibility during these times, which in reality is not always possible. Fundamentally these changes to the contract will reduce the pay for most medical specialties and will still negatively impact women the most due to them being more likely to choose to work LTFT.

**Changes to the junior doctors’ contract – interview data**

Of those interviewed before the proposed changes to the junior doctors’ contract, the majority of specialty trainees felt that the pay arrangements in place were fair and reasonable, and many respondents felt that compared to the private sector, that gender pay equality was good. One female paediatrics trainee said:

“There’s still a quoted gender pay difference in the private sector, we should be celebrating the fact that it’s less so in the NHS. I can’t speak on the behalf of the whole NHS but certainly at the moment with doctors our pay grades aren’t selected on whether you’re a man or a woman, I think we should be an example to the private sector” (Female paediatrics trainee, interview 10).

Issues surrounding changes to pay, in light of the changes to the junior doctors’ contract were mentioned mainly by female trainees who were working LTFT or contemplating switching to LTFT in the future after having children. The state argued that the abolition of annual pay increments allowed for equal pay for work of equal value as pay increases were based on completing stages of the training programme. The interview with one of the BMA officials shows that this angered female LTFT trainees as the equal pay rhetoric the state was using contradicted the reality of the detrimental effects of the proposed contract on LTFT trainees’, who are usually female, pay:

“I am finding interesting, the anger expressed at the principle of equal pay because that’s the term the Department of Health used to get rid of annual pay progression. It’s interesting to talk about equal pay and equal value and
actually have women get angry about that because it was used against them...the Department of Health keep saying its principle is equal pay for equal value. But every time they repeat that you can see some anger and frustration, particularly our junior LTFT doctors because they take that as meaning ‘you are slowing down and further disadvantaging my progression in the profession’” (BMA official, interview 45).

As a consequence of the changes to the junior doctors’ contract, female specialty trainee interview respondents felt that the proposed contract changes would create a gender pay gap in medicine:

“There is likely to be more of a pay gap. Medicine is quite a good career in terms of its gender pay gap isn’t very big but they think as time goes on that will become more as more females will stay at lower levels longer and get paid less in general” (Female GP trainee, interview 6).

Officials of the BMA commented on the aspects of the proposed and imposed junior doctors’ contract that are likely to have a negative impact on specialty trainees’ pay, and consequently the gender pay gap in medicine. One aspect concerns the pay protection put in place for junior doctors currently in employment. Specialty trainees who are ST3 or above will have their pay protected up to August 2022, or when they finish their training. Therefore it was felt that as more women are increasingly entering the profession, the gender pay gap would be widened:

“the new pay structures they are introducing will disadvantage women who have children…and the pay protections put in place will stop current doctors from being disadvantaged but in the future the gender pay gap will be even worse than it is now” (BMA official, interview 43).

Harries et al (2015) also found there were concerns that this would be the case of women specialising in surgery. The agreement to protect pay for trainees switching career tracks due to care responsibilities can be considered a significant protection of women’s interests. As discussed in the previous empirical chapter (chapter five), female trainees are more likely to switch to general practice from hospital specialties for childcare reasons, as there are fewer unsocial hours in general practice. Therefore their pay would be adversely affected. One of the BMA officials (interview 43) stated if
a specialty trainee at ST3 level was to change specialty under the initial proposed contract they would have seen £11,000 per annum reduction to their pay. Therefore the state is also “encouraging a narrow career path” (BMA official, interview 43) with disincentives to take time out to work abroad and conduct research. It could be argued that the state has made the option of switching specialties less attractive in order to lower the amount of time it takes for trainees to complete their training programme to address understaffing issues at consultant level, although there are fears this would lead to “a homogenous workforce that will be insular and stagnant” (Ahmed et al, 2015).

Some respondents felt the proposed changes to the junior doctors’ contract at the time of the interviews reflected the feminisation of the profession. These respondents stated they felt the negative implications of the proposed contract, as mentioned above, were introduced due to more women entering the profession, in turn lowering the overall status of the medical profession:

“In general, people tend to feel like ‘once we’ve got so many women doing this job, it’s probably not as hard as we originally thought it was’. It’s kind of a dumbing down of the profession...I think you get less respect for the profession I think. I think that’s mirrored with what’s going on with the junior doctors contracts now as well. Its kind of like ‘well all these women, they don’t need that amount of money, we need to bring it down a bit’” (Female GP trainee, interview 24).

Specialty trainees’ perceptions of the status of the medical profession

The interview data also shows that specialty trainees perceive the medical profession to be changing, in terms of its status and public attitudes towards it as a profession. The medical profession as a whole has been typically described as having ‘elite’ status. However, the literature review (chapter two) highlights that once more women enter a profession, its status is likely to become devalued (England, 1992; Kilbourne et al, 1994). Interview questions explored what impact specialty trainees felt the recent feminisation of the profession has had on medicine’s status. Respondents commented on their perceived views of the changing attitudes towards the status of medicine, as well as differences in status between the medical specialties.
The vast majority of respondents stated that they felt surgical specialties were of the highest status out of all the medical specialties. Respondents frequently made links between surgery being traditionally male-dominated and its long-standing high status, often described by respondents along the lines of an “old boys club” (female paediatrics trainee, interview 8). Another respondent said: “surgeons maintain that ‘air’” (male anaesthetics trainee, interview 11). In contrast, most respondents across all three specialties felt general practice and psychiatry are viewed as having a lower status. General practice was described as being seen as “the easier option” (female GP trainee, interview 2) by most doctors, and some respondents said their seniors described general practice in this way during their time at medical school:

“At the end of my surgery placement, the consultant came over to me and said: ‘I think you’re better off just being a GP, don’t you?’...it was really offensive...he was making out GP wasn’t as good and that GPs don’t have the same drive” (Female paediatrics trainee, interview 21).

From the interview responses regarding medical specialty status, a link can be identified between medical specialties having female-related attributes and the specialty being seen as having lower status. For example, specialties with a perceived better work life balance, such as general practice, psychiatry and dermatology, correlated with specialties seen as having a lower status. Therefore, specialties that have working time arrangements that are seen as more family-friendly, and thus more attractive to women, are perceived to have lower status. Similarly, female paediatricians feel their specialty has a lower status compared to other medical specialties; one respondent considered that her specialty is seen as “fluffy” (female paediatrics trainee, interview 25) because of more women working in the specialty, and the specialty’s maternal connotations of caring for children.

Interviews also showed that the overall perceptions and attitudes towards the medical profession are changing, both from the specialty trainees themselves and from the general public. To explore this, respondents were asked whether they felt the profession was becoming more “humanised” as predicted by Elaine Riska (2001), now more women are entering the profession. The majority of respondents, both male and
female, agreed. Respondents commented the profession as a whole is becoming “less paternalistic” (male anaesthetics trainee, interview 4), with less focus on the doctor being in control and “the doctor knows best” (male anaesthetics trainee, interview 9).

CONCLUSION
This empirical chapter aimed to explore how specialty trainees from anaesthetics, general practice and paediatrics experience employment in terms of working time, career planning, pay and the profession’s status. In addition, it examined whether these employment experiences are gendered given the increasing number of women entering a traditionally male-dominated, elite profession. A number of key findings can be taken from this chapter, which will lead into further discussion in chapter eight (discussion chapter).

It can be seen that the main findings revolve around the complexities of working time in medicine, which in turn create gendered employment experiences, and that these experiences also differ across the three medical specialties in terms of how specialty trainees manage and cope with working time and their personal lives. There also appears to be a mismatch between the rhetoric of how specialty trainees expect the working time to be in a medical specialty compared to the reality they experience. This can be seen with the trainee GPs, who chose general practice with the aim to better manage their working life and personal life due to not having to work unsocial hours. However, in reality the sheer work intensity and time pressures means that GP trainees feel they are working excessively and over their scheduled working hours. Likewise, female paediatrics trainees expected to achieve a good work life balance in their specialty due to the abundance of female role models seen working within the specialty, but the paediatrics trainees interviewed have challenging working time experiences of excessive, unsocial working hours alongside moving workplace location every six months. It can also be seen that female trainees with children have multiple struggles when attempting to balance their working life and their personal life commitments. Therefore the interview data suggests that working time arrangements in medicine require change to better suit the changing demographics of its workforce, which is discussed in more detail in the discussion chapter (chapter eight).
There is a clear consensus across all respondents that the line between remunerated and non-remunerated work is blurred, as well as time that is classified as working time and personal time. All respondents comment on the tolls of working long, unsocial hours, and a gendered impact can be seen in relation to female respondents. Even though there are barriers caused by the current training system, such as the vast amount of additional work and problems associated with perceptions of requesting study leave, there is also a common view amongst all respondents that they have to “get on with it”, as though that is a guaranteed expectation of the professional role of a doctor.

Overall, this findings chapter shows the complex context of the medical profession intersects with the ways specialty trainees attempt to manage their work life and home life, and navigating through the medical career. This creates challenges, particularly for female specialty trainees many of whom give birth and then assume main childcare responsibilities during their training programme. The management of pregnancies, leaves and the return to work take on particular complexity in this professional structure where the trainees are left to organise and manage many of the processes of support themselves. In addition, the findings also show that specialty trainees’ experiences of medicine are changing in terms of the status and attitudes towards the profession, with a shift away from paternalistic care where the doctor knows best towards collaborative and more communicative care with the patient, which most specialty trainees feel is due to more women entering the profession. It is also important to note the role the state has played as the employer when proposing changes to the junior doctors’ contracts at the time of the interviews, and how its actions may have negative consequences for the medical profession, and particularly for women within the profession.

Next the focus turns to the employment experiences of consultants, salaried GPs and GP Partners. Firstly to explore what it is like working within these senior roles in medicine; secondly to find out whether there are also gendered experiences at the higher levels of the medical hierarchy; and thirdly to consider whether there is again a
disparity between experiences at trainee level within a specialty compared to experiences once the destination role is reached.
CHAPTER SEVEN
EMPLOYMENT EXPERIENCES OF CONSULTANTS AND GPs

INTRODUCTION
This findings chapter focuses on the employment experiences of consultants and GPs employed within a region of NHS England. Throughout this chapter these individuals are collectively referred as working within their “destination roles”. Consultants and GPs are discussed separately to specialty trainees in this thesis as their employment differs in terms of their employment relationship, pay determination and job responsibilities (as highlighted in the context chapter). Also, consultants and GPs have most likely seen the changes to the profession first-hand over a longer period of time compared to specialty trainees. Therefore, they are more likely to have witnessed the impact, if any, of more women entering the profession, although disentangling the different causes of changes may be still be difficult even for those ‘living’ through them. In addition, the full extent of feminisation is yet to be seen at consultant level because of the recent feminisation at the lower levels of the medical hierarchy, causing a ‘generational lag’. Therefore this raises the general question - how do the employment experiences of consultants and qualified GPs compare to those of specialty trainees? Is there a disparity between specialty trainees’ expectations and the reality of the destination job within their chosen medical specialty? Perhaps it is also the case that consultants and GPs have so far been more immune to the downgrading of pay, and other working conditions, compared to specialty trainees. For example, the state is yet to implement changes to consultant contracts, and GPs were regarded as having been favourably treated when their contracts were renewed to include less unsocial working hours, under new Labour in 2004.

The aim of this chapter is to explore these questions, and the research questions, with a specific focus on working time, careers, pay, childcare and the status of the medical profession. This chapter’s findings are separated into three sections, representing the three key themes that emerge from the data analysis. The same broad themes from the previous empirical chapter also emerged from interviews, and frame the analysis
of the interview data in this chapter. The first theme relates to how this group manages their working time, and whether there are any differences between the expectations of what working time would be like at specialty choice stage versus the reality of working within the specialty after training. The second theme is how these individuals manage their careers, particularly with regards to applying for pay-related awards and navigating through maternity and childcare responsibilities. The third theme encompasses issues surrounding equal pay and this group’s perceptions of the feminisation of the medical workforce, and the subsequent impact on service delivery. Consultants and qualified GPs are discussed separately under each theme due to the differences between the contexts they work within.

The consultant findings from the hospital case study are based upon semi-structured qualitative interviews with three consultant paediatricians and three consultant anaesthetists from the same NHS Trust Foundation Hospital, NHS England. At the time of the interviews, the anaesthetics department consisted of thirty-three consultant anaesthetists, and the paediatrics departments consisted of a total of eighteen consultant paediatricians. It should be noted the consultant paediatricians are distributed across three departments: community paediatrics, children’s ward and children’s outpatients. Three of these consultants work solely within community paediatrics and, out of the remaining fifteen consultants, nine work within both children’s outpatients and on the children’s ward, and six consultants work within children’s outpatients. Within the region studied, this NHS Trust Foundation Hospital employs a higher number of anaesthetists and paediatricians compared to most other NHS hospitals in the geographic area. To supplement this data, interview data from two consultants from anaesthetics and paediatrics, with dual-responsibilities as Training Programme Directors (TPD) are also used. The findings concerning general practice are based upon five interviews with salaried GPs (n=2), GP Partners (n=2) and a Practice Manager (n=1) from the same region of NHS England. Interview data from a GP TPD is also used to support the findings. The GP respondents all worked within the same geographic area as the hospital case study and the specialty trainees’ sample in the previous two empirical chapters. In addition, interviews with BMA (n=4) and Royal College (n=2) officials also contribute towards the findings.
Similarly to what has been discussed in the previous chapter, the context of the medical profession is also fundamental in shaping the experiences of consultants and qualified GPs within this chapter. The contrast between general practice and hospital medicine is presented below to contextualise the analysis. General practice as a medical specialty is unique for a number of reasons. Firstly, it is structured as a small business, with the GP Partner(s) responsible for the successfully running of the practice, including financial responsibilities as well as delivering excellent patient care. Secondly, the working hours of general practice are different to most hospital specialties since 24/7 care is not provided by the vast majority of GP practices, with most practices operating 8am to 6pm, Monday to Friday. This is a consequence of the changes to GP contracts in 2004, where out-of-hours care provisions became optional thus changing standard working hours from a 24-hour care model.

Contextually, general practice as a medical specialty has also been changing in other ways in recent years. Firstly, it is known from other research that the work pressures within general practice are increasing. The most recent report from the eighth National GP Worklife Survey highlights this, showing that GPs are reporting that they feel more stressed due to ‘increased workloads’ and ‘changes to meet requirements of external bodies’ since the first survey in 1998 (Gibson et al, 2015). There is also an ongoing recruitment crisis within general practice, currently it is reported that 12% of GP posts remain unfilled (The Guardian, 2017). In addition, the GP workforce is also feminising, since the most recent NHS data shows over 53% of GPs are now women (NHS Digital, 2016). It should also be noted that the aging population is growing, again adding to the pressures on GP services.

The hierarchical structure of general practice is set out differently to hospital-based medical specialties. After GP specialty training, a qualified GP may choose to become a salaried GP, a GP Partner or locum. In general practice, the top of the hierarchy is the GP Partner, who is effectively self-employed and the owner, or part owner, of the GP Practice. Salaried GPs are employed directly by the practice under a standard NHS contract. Also at the practice is a Practice Manager, who is mainly responsible for the
day-to-day running of the practice. Therefore, even though all of these individuals
come under the umbrella of ‘general practice’, their experiences of work can be very
different. However the hierarchical structure post-specialty training in medicine is
different. After specialty trainees complete their specialty training, they have the
option to apply for a consultant post. Consultants are employed through a NHS local
employer and their terms and conditions are set by a national consultant employment
contract, which is currently under review by the DH.

SECTION ONE: MANAGING AND COPING WITH WORKING TIME

CONSULTANT WORKING HOURS
Both male and female consultants interviewed commented on how their work life
balance has improved since completing their specialty training. Consultants
interviewed appear to have more ability to plan and control their working hours now
they have more seniority. The increased ability to control work life balance as
consultants progress through their careers does not appear to be a gendered finding.
In addition, the interview data shows it has encouraged women to feel enabled to
work full time and have a family, both in anaesthetics and paediatrics. All of the female
consultants interviewed have chosen to work full-time because they are able to
balance childcare commitments and work even under full-time contracts. The TPD for
paediatrics explained that consultant paediatricians are more likely to work full-time
compared to trainee level because consultants:

“have more control over what they do, as a trainee you’re basically told ‘this is
what you’re gonna do, you’re gonna work a week of nights’ and that’s quite
difficult to manage...whereas as a consultant you’re much less likely to be doing
that and you have the ability to plan your job around what you need so if you
have no childcare on certain days of the week as a consultant you can plan for
that...as a trainee it’s [working hours] just given to you rather than you
planning it” (Male paediatrics TPD, interview 48).

However this finding may be unique to the two hospital-based specialties studied and
also influenced by the way working hours are structured within the NHS Trust hospital
studied. For example, in paediatrics, the two female paediatricians interviewed
worked ‘concentrated hours’ to allow them to have full weekdays off to look after their children. They both stated this is why they applied to the particular NHS Trust studied, as it is a specific feature of this paediatrics department. The consultant paediatricians interviewed feel this working arrangement is put in place because paediatrics departments are more likely to recognise the need for family-friendly working hours since it is a specialty dominated by women, who are more likely to have childcare commitments.

Similarly, the female consultant anaesthetist interviewed commented on how the structure of the working hours in anaesthetics can facilitate women with childcare responsibilities having the ability to work full-time. This is because anaesthetics can often be sessional, thus once operations have finished and the patient has come around from the anaesthetic, the consultant anaesthetist can leave. Thus the working day is structured and there is a lesser requirement for continuity of patient care. It also means that anaesthetists are less likely to have responsibilities and concerns for specific patients after returning home. However, more acute and understaffed specialties, such as Accident & Emergency, may struggle to put in place these working hour structures to enable women to work full-time more easily as the workload is more unstructured and unpredictable.

The increased ability to control working hours appears to facilitate organising childcare and family life in both hospital-based medical specialties. However, again, this may be unique to paediatrics and anaesthetics rather than hospital-based specialties as a whole. For example, a female consultant anaesthetist said it is easier for her now to organise childcare if one of her children is sick:

“I can control my rota...if one of them is sick, I can look at the rota and think it looks like there will be cover if I don’t go into work this morning but this afternoon there’s no one to cover...so that’s great. That’s the thing about anaesthetics, there’s so many of us around to cover. It’s not like having three cardiologists when one’s on holiday, then another goes off sick, you probably couldn’t do it then...but when there’s twenty of us you don’t feel as bad, they’ll cope” (Female consultant anaesthetist, interview 31).
Therefore, the amount of staff available to cover shifts in anaesthetics appears to be an important aspect of how consultants can alter their working hours. However, in paediatrics, there appears to be a view that childcare arrangements are an expected part of working life due to the nature of the work. One female consultant paediatrician commented on this:

“It’s highly likely that people who want to work with children are very likely to want to have them so maybe they’re more understanding of work life balance. And I think it’s this that’s made me stay in paediatrics rather than going to something that’s more acute, like A&E or intensive care...I couldn’t face going back and doing all of those night shifts, and rotas and trying to fit it in with childcare but now it’s steady and I now have time to do both” (Female consultant paediatrician, Interview 34).

This shows how a specialty has adapted to ensure female consultants, as they represent the majority of consultant paediatricians, can balance work and family life. This adaptation made by paediatrics does appear to be a locally driven initiative by the Trust researched, based on the culture and expectations of the specialty, rather than a specific nationwide NHS policy. Even though hospital-based consultants have more control over their working hours and their ability to manage home and work life, this does not take away from the intense, heavy workloads and long working hours consultants experience whilst they are in the workplace. For example, the RCPCH sets recommendations that a paediatrics consultant should be available 12 hours of every day (RCPCH, 2015). In addition, all consultants interviewed commented that the NHS relies on their “goodwill” of working beyond their scheduled working hours to manage the high volume of work.

**GP WORKING HOURS**

A consensus across the general practice interviews concerned difficulties managing working time, particularly due to high work intensity and their lack of control over working hours. As mentioned GP contracts were changed in 2004, in a bid to attract more people to the specialty by reducing the 24-hour care models. During this time, the BMA and Department of Health agreed on a new ‘model’ contract for all salaried GPs employed on or after 1st April 2004. This contract states the model number of full-
time working hours should be 37.5 hours per week. However salaried GPs can choose to work up to 48 hours a week to comply with the WTR (1998).

Despite these changes to working time arrangements, all qualified GPs interviewed mentioned working time as being a challenge in their current role. Firstly, qualified GPs feel they have little control over their working hours. This is in contrast with the hospital-based consultants who often stated they have more control over their working time since completing their specialty training, even though they are more likely to work during ‘unsocial hours’ of nights and weekends. This is also a stark contrast to specialty trainee level where trainees were more likely to choose general practice to achieve a better work life balance compared to hospital medicine. The lack of control over working hours within general practice appears to stem from the shortage of GPs and the onus being solely on the GP to conduct appointments, often with little support. Therefore there are limited cover options, so a qualified GP would struggle to be away from the practice, as appointments would have to be cancelled. In contrast an anaesthetist, as a part of a much larger hospital team, is more likely to have the option to be away from the hospital as there are more cover options. The interview data also suggests that the size of the GP practice has an impact on control over working time, with GPs from smaller practices having less control of their working hours. This is similar to the consultants with regards to smaller hospital specialties, such as cardiology, where there is limited cover for consultants to have time off at short notice and work more flexibly. The findings from interviews with GPs are the contrary to what Crompton and Lyonette (2011) found in their research of GPs, as they argued GPs have more control over their working time as they become more senior. However it does appear that this is dependent on the size of the practice, and since those interviewed were all from smaller practices, perhaps they feel they have less control. When asked about control over working hours, one female GP partner said:

“Although I do have regularity, well some, during my working week because we are a small practice we all have to cover until 6.30pm and this normally goes on until 7pm. Then if someone is on holiday, I have very late finishes several times during that week. So whilst I am not working weekends, and that’s great, I just find my current working pattern isn’t particularly family friendly and it’s ironic
because when I compare my working life now compared to what my husband’s is like, as a consultant anaesthetist in a hospital – it is actually a lot harder to manage childcare around my working patterns than his” (Female GP Partner, Interview 38).

As seen in the statement above, the GP’s main issue with the lack of control over working hours is the impact it has on childcare. Those with childcare responsibilities, all women in our sample, said it was a struggle to work full time as a GP because the working hours are concentrated, long and intense. Therefore it could be suggested from the findings that on qualification female trainees would struggle to work full-time hours in general practice and take responsibility for childcare. Secondly, the interviews also show that the “very focussed and concentrated hours” (male Practice Manager, interview 37) within general practice makes it difficult for GPs to work full time hours. All of the qualified GPs interviewed worked part-time, and the three GPs at the practice manager’s practice also all worked part-time. Perhaps it could be said that this is due to the majority of the participants being female and thus they are more likely to work part time for childcare reasons. However, the male GPs interviewed also worked part-time. One male salaried GP states that working full-time in general practice would lead to burnout:

“I work 7am until 7pm, I don’t do all the nights. Even though they’re long days, I can afford to work three days so I don’t keel over and die. Working five days in general practice is too much so I work less and I earn less to avoid burnout.” (Male salaried GP, Interview 40).

This statement highlights that the working pressures within general practice and the difficulty to work full-time go hand in hand, and that the work intensity is different to that found in hospital medicine. The interview data show that general practice typically consists of fewer days, which are more intense, whereas hospital medicine appears to be shorter hours over a longer period, and includes nights and weekends. Even though the GPs interviewed decided to work part-time to alleviate some of the pressures and stress associated with general practice, most qualified GPs interviewed commented on how they felt stressed and tired even when working a reduced number
of hours. The same salaried GP mentioned this was the case, especially towards the end of his shifts:

“I often reach the point at the end of the day where I slow down and I really need to be slow about making my decisions and think about what I am going to say next...and I don’t like having to do that. I’m just not at my best at the end of the day” (Male salaried GP, interview 40).

The official interviewed from the Royal College of GPs supports this finding, and says the long, intense working hours within general practice is contributing towards the recruitment crisis:

“long working days causes burnout more quickly so a lot of women [GPs] in their late 30s and 40s left as they say ‘if I can't practice safely, I won’t practise’” (female official of RCGP, interview 46).

A lack of support during appointments is also felt by the GPs interviewed to lead to burnout and stress, since “in hospital medicine you have a team of people surrounding you and supporting you with procedures” (male Practice Manager, interview 37). This issue has been raised by the Royal College of GPs and they are looking at introducing new roles to support GPs to alleviate tiredness and improve confidence in decision-making. Similarly, Gibson et al (2018) found that the perceived lack of support in general practice discouraged medical students to choose it as a career option to specialise in.

There are a number of contextual issues present here which create the dynamics seen from the interview data concerning working time. The model of general practice has created a system of long, intense working hours combined with a shortage of GPs. It could be argued that the state has played a key role in this for a number of reasons. Firstly, the recent changes to GP appointment times have arguably increased the intensity of GPs’ working time. In April 2014, it was suggested by the NHS that GPs should shorten appointments to ten minutes to allow for more patients to be seen since the population is growing and ageing. However, as highlighted in the interviews with GPs, very few appointments are restricted to ten minutes due to patients having
more complex illnesses and more than one issue to discuss during each appointment.
Therefore, not only are appointments more complicated, working time is also longer because patients are taking longer than the recommended ten minutes to be dealt with.

Overall, all GPs interviewed felt they did not achieve a good work life balance, despite working part time hours, whereas consultants from paediatrics and anaesthetics felt on the whole that they did since they have qualified from specialty training. The interview data suggests that the experiences of working time at specialty trainee level and post qualification are reversed for hospital-based specialties. However the time pressures and poor work life balance appears to become more entrenched for qualified GPs.

SECTION TWO: NAVIGATING AND MANAGING CAREERS

The second theme that emerges from the data concerns how consultants and GPs manage and navigate their careers. Again, consultants and GPs are discussed separately. Beginning with consultants, they can further their careers in various ways, such as entering academic posts at universities, becoming educational supervisors for training programmes and/or conducting research within their specialist interest. These additional roles are often completed outside of clinical hours, similarly to the additional work specialty trainees are required to do to complete their training or enhance their CV. However it is not a necessity for consultants to take part in activities beyond their clinical job role, yet the interview data shows that consultants are rewarded financially for going above and beyond their daily clinical roles, through Clinical Excellence Awards (CEAs).

CEAs were introduced when the NHS was created in 1948, albeit under a different title – ’distinction awards’. Yet the premise remains the same that they were introduced to encourage consultants to work for the NHS, rather than in private practice where consultants have the ability to earn a much higher salary. Consultants are required to
self-nominate themselves for a CEA, and their application form is judged on the basis of how they have contributed “over and above” their contracted working arrangements. The 2016-17 CEA application form required consultants to provide evidence that they have gone “over and above” their contracted job role in five domains. The five domains are:

1. Delivering a high quality service
2. Developing a high quality service
3. Managing and leading a quality service
4. Contributing to the NHS through research and innovation
5. Contributing to the NHS through teaching and training

Although consultants are not required to go “over and above” in each domain in order to receive an award, it is recommended by the Advisory Committee on Clinical Excellence Awards (ACCEA); many Royal Colleges and the Medical Women’s Federation (MWF) that domain sections on the application form are not left blank to improve the chances of successfully receiving an award. The Guidance for Applicants 2016 document goes into further detail on what consultants can include as their domain examples. Within the guidance documents there is a lot of emphasis on displaying evidence of going “over and above” in a “cost-effective” manner (ACCEA, 2018). Arguably this places more importance on consultants acting within cost constraints rather than on the quality of patient care. It should also be noted here that to receive the higher awards at national level (levels 9 – 12) applicants must provide further evidence for domains three, four and five, which promote leadership, research and teaching.

The BMA noted in their 2014 Annual Representatives Meeting (ARM) that female and BAME consultants are disadvantaged in the CEA allocation process, since they found white, male consultants receive the majority of awards. The most recent CEA data from the 2013 round shows that considerably fewer females than males apply for the awards, with 1362 men applying compared to just 320 women. The data also shows that the specialties dominated by men tend to receive a greater number of awards. For
example, consultants from Obstetrics and Gynaecology received 9 out of 317 awards whereas those from Surgery received 49 awards (the second highest specialty after General Medicine). In addition, it should be noted that the female dominated specialties (such as obstetrics and gynaecology, and radiology) have fewer applications compared to the male dominated specialties (such as surgery and anaesthetics). This research aimed to explore why consultants feel fewer women are in receipt of CEAs. The majority of consultants interviewed from both specialties agreed that they feel female consultants are disadvantaged in the CEA allocation process. The majority feel this is because female consultants are less likely to put themselves forward for an award, since the criterion states that CEAs are awarded to consultants who go “over and above” their contracted duties. The unlikeliness of female consultants self-nominating is seen by the consultant respondents to stem from the number of hours women are able to commit to work due to their childcare commitments. All of the female consultants interviewed commented that this was the reason they have never applied for an award. For example, when asked if she feels women are disadvantaged in terms of the allocation of CEAs, a female consultant paediatrician said:

“I think it does because you have to apply for it and I have chatted about this quite a lot with my colleagues in that none of my female colleagues would apply for one…One or two of my male colleagues have told me to apply for one and have said ‘what have you got to lose?’ but how I feel at the moment is that I haven’t been able to give my all to work because I have had so much to juggle with childcare. I know I am not performing to the level that I am capable of because I can’t devote as much time to work as I could have done before I had children, and therefore I didn’t feel as deserving as other people who give more of their time and do more with their spare time, and stay later. Whereas I’ve had to get a bit militant about leaving on time to pick the kids up from nursery” (Female consultant paediatrician, interview 34).

This statement shows that within this paediatrics department there appears to be a strong view amongst consultants that CEAs are awarded based on notions of presenteeism and working long hours, rather than the actual quality of patient care. From the interviews, consultants in anaesthetics also felt the self-nomination process is subjective and favours those without childcare responsibilities, who are more likely to be men. One male anaesthetist said:
“It’s a fairly subjective process and I would imagine that because it’s supposed to be for people who are doing over and above what their job plan is, then if you’ve got a lot of family commitments, and that’s more likely to be women than men, then you’re less likely to have a load of spare time to do lots of extra curricular stuff. I’ve certainly noticed in our department that some of the most productive people in our department don’t have small children. If you have small children pre-primary school, you just don’t have the spare time to be doing lots of reviews and audit quality type stuff that gets you clinical excellence awards (Male consultant anaesthetist, Interview 35).

Both of these interview statements highlight the views amongst most consultants interviewed, as they feel the criterion for CEA applications is vague and subjective, as well as being perceived to merit those with the ability to work longer hours. The potential impact this has on pay and a subsequent gender pay gap amongst consultants is discussed later in the final section this chapter.

GP Partners and salaried GPs can progress and enhance their careers in other ways. For example, through gaining a ‘specialist interest’ to conduct research within, they can also become educational supervisors and TPDs through their HEE region. However, the interview data shows that both salaried GPs, and GP Partners especially, focus largely on the day-to-day work of the GP Practice. As mentioned earlier, clinical working hours within general practice are long and very intense, with the Practice Manager (interview 37) commenting that GPs “work 10-12 hours of intense pressure throughout the day, actually that’s a bit optimistic, it’s more like 14 hours”. Therefore, perhaps there simply is not the time available to conduct additional work to progress their careers, instead it is about conducting work that keeps the practice profitable and efficient as they are essentially small businesses that the GP Partner is responsible for.

The intense working hours in general practice also appear to be impacting on the number of GPs wanting to progress their careers to become GP Partners. In 2014 the BMA reported that GP Partner numbers were falling, whilst the number of salaried and locum GPs grew by 400% between 2003 and 2013 (BMA, 2014). Overall the GP workforce is predominantly female, and the number of women entering the specialty continues to rise, meanwhile the number of GP Partners continues to fall, and the
majority of GP Partners are men (NHS Digital, 2016). The RCGP official interviewed says a “retirement boom” (female RCGP official, interview 46) has played a key role in the reduction of GP Partner numbers. In addition, a recent survey conducted by Pulse (2018) of 500 GP Partners finds 27% of respondents said they wanted to quit their Partnership role due to unmanageable workload pressures and concerns about premises costs. It should also be noted that GP Partners are working within a context of rising patient numbers due to a growing and ageing population; and reductions to GP funding (Pulse, 2018).

In addition GP Partners are not entitled to many of the employment rights salaried GPs receive, such as NHS maternity leave and pay, because they are effectively self-employed. The interviews with the two GP Partners show that their employment conditions during pregnancy and maternity leave were not favourable, as their partnership agreements did not factor in maternity leave rights and pay. For example, one GP Partner said:

“As a GP partner you get very few employment rights because you are not technically an employee...you don’t get any access to modern, progressive terms and conditions that perhaps look after your maternity rights, and that is just absent...in the hospital specialties you’re covered by good maternity rights and you get a pretty good financial deal. However in general practice, you have to negotiate your terms and conditions for your maternity leave...and when you’re a partner the partnership agreements are like something that have come out of the ark! Many of them don’t allow you to take twelve months off...and the one I am currently in, I have to self-fund the locum who will be covering my shifts for the last three months of my maternity leave, and after six months it’s not even acknowledged that I am allowed to take anymore maternity leave” (Female GP Partner, interview 38).

These findings indicate that these main aspects of GP Partnership roles are not compatible with having a family. Therefore it appears that the intense working hours combined with the high level of responsibility and lack of maternity rights and benefits is dissuading qualified female GPs from becoming GP Partners. In addition as more women enter general practice it is likely that GP Partnership numbers will continue to fall, as it is not an attractive career for women with children in its current format.
This section shows, similarly to specialty trainees, that career advancement in consultant and GP posts is dependent on the ability to work intense, extremely long hours and beyond clinical hours. Therefore the findings indicate that female doctors struggle to balance family life at the same time as this style of working time so tend to not opt for CEAs or GP Partnership roles. Inevitably this is likely to have a gendered impact on pay, which is discussed in the next section.

**SECTION THREE: GENDER PAY GAP AND PERCEPTIONS OF FEMINISATION OF THE MEDICAL PROFESSION**

Issues mentioned in the previous section regarding women’s difficulties accessing career progression due to extreme working hours appears to be an indicator of why there is a gender pay gap of 14.1% in medicine (NHS Digital, 2017). As highlighted in the context chapter (Chapter Three), hospital consultants’ pay is determined differently to that of specialty trainees and GPs so issues surrounding consultants’ and GPs’ pay are discussed separately in this section. In terms of consultant pay, Clinical Excellence Awards (CEAs) have faced scrutiny over the last ten years from the BMA and academics for contributing to widening the gender pay gap in medicine (Abel and Esmail, 2006; Connolly and Holdcroft, 2009). Secondly, the state has suggested changing consultant contracts, which could have detrimental consequences for consultants’ pay, as seen for specialty trainees in the previous findings chapter with the changes to the junior doctors’ contracts.

**CONSULTANTS’ PAY**

Consultants employed by the NHS are paid a basic salary, which is predetermined centrally by the Department of Health on recommendations set out by the DDRB. Consultants employed under the 2003 Consultants contract are paid a basic salary based on a threshold pay scale, consisting of eight pay thresholds (see Table 8 below). The first year’s basic pay of a consultant employed under this contract is £76,761, which rises in steady, annual increments across five pay thresholds during the first five years working as a consultant. The next three pay thresholds are reached every five
years, meaning it currently takes a consultant nineteen years to reach the top basic annual salary of £103,490.

Table 8: Consultants’ 2003 contract basic pay thresholds

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Years completed as a consultant</th>
<th>Basic salary (£)</th>
<th>Period before eligibility for next threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>76,761</td>
<td>1 year</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>79,165</td>
<td>1 year</td>
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<tr>
<td>3</td>
<td>2</td>
<td>81,568</td>
<td>1 year</td>
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<tr>
<td>4</td>
<td>3</td>
<td>83,972</td>
<td>1 year</td>
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<tr>
<td>5</td>
<td>4</td>
<td>86,369</td>
<td>5 years</td>
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<tr>
<td>6</td>
<td>5</td>
<td>86,369</td>
<td>4 years</td>
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<td>86,369</td>
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<td>86,369</td>
<td>2 years</td>
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<td>9</td>
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<td>86,369</td>
<td>1 year</td>
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<td>10</td>
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<td>92,078</td>
<td>5 years</td>
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<td>10</td>
<td>92,078</td>
<td>4 years</td>
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<td>2 years</td>
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<tr>
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<td>18</td>
<td>97,787</td>
<td>1 year</td>
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<tr>
<td>20</td>
<td>19</td>
<td>103,490</td>
<td>-</td>
</tr>
</tbody>
</table>

In addition to their basic pay, consultants can also nominate themselves for a Clinical Excellence Award (CEA) to enhance their basic salary. As mentioned earlier, and in more detail in the context chapter, the monetary value of CEAs can contribute to a significant increase in consultants’ annual pay. As seen in Table 2 (see page 76) CEAs can add as much as £77,320 per annum for the highest national award.
To explore the gender pay gap further, an analysis was also conducted on the
distribution of local CEAs at the NHS hospital Trust in this research for both paediatrics
and anaesthetics. In 2016, no consultants in any specialty in the researched NHS
hospital Trust received a national CEA (levels 9-12). However, 65 consultants across all
medical specialties within the NHS hospital Trust received a local CEA award (levels 1-
9), and approximately 70% of those were awarded to male consultants. Six consultant
paediatricians were successful in gaining a local CEA, five of whom were male.
Information is not available on the proportion of female paediatricians who applied for
an award and were successful, but the evidence shows there is an unequal gender
distribution of awards within the NHS Trust researched. In addition, the female
recipient’s award level was less (level two) compared to all the male recipients, the
majority of whom gained levels four or five. This finding could be used to support the
previous finding that female paediatricians are less likely to apply for CEAs. It should
also be highlighted that there are ten male consultant paediatricians employed by the
NHS Hospital Trust in this research, thus 50% have been successful in achieving a CEA,
whereas just one of nine female consultant paediatricians at the NHS Trust hospital
successfully gained an award.

The same analysis was also conducted for consultant anaesthetists. At the NHS
hospital studied, fourteen consultant anaesthetists successfully gained a CEA in 2016.
Male consultants received eleven of these awards, whereas female consultants gained
three. In 2016, there were 33 consultant anaesthetists at the Trust, fourteen female
and nineteen male. Therefore, similarly to paediatrics, there is an unequal distribution
of award allocations compared to the gender distribution of the workforce. Drawing
from the interview findings and this secondary analysis of CEA distribution, it does
appear that female consultants may be less likely to apply for CEAs.

Two of the consultants interviewed stated they had applied for an award - a male
consultant paediatrician, and a female consultant anaesthetist. Similarly to the female
consultant paediatrician (interview 34) mentioned earlier, the female anaesthetist said
she applied for the first time for a CEA because her cardiologist husband encouraged
her to. However, she also said “most of my female colleagues don’t bother”
(consultant anaesthetist, Interview 32). This finding can be interpreted in two ways. Firstly, perhaps there is a difference between men and women in terms of having the confidence to put themselves forward for an award, particularly one that is financially motivated. For example, many of the consultants interviewed felt that women are more likely to “put themselves down” and are less motivated by money. Secondly, it may then be the case that women feel as though they have to justify applying for an award, or contemplate applying for an award, by saying someone else has encouraged them to do so and thus it is well earned and deserved.

The lack of women self-nominating for CEAs may also be due to a number of other reasons. Firstly, as mentioned previously, the interview data highlights the high value and importance doctor’s place on those who spend more time at work, in terms of being entitled to achieve additional remuneration. Merit pay based on going ‘over and above’ standard hours could be linked to the deep-rooted context surrounding the nature of medical work, since traditionally medicine is associated with working long, unsociable hours whilst being physically present in the hospital. Secondly, a number of consultants reported that the CEA application form is very time-consuming and focuses on work completed outside of standard working hours that is leadership and research focussed. Therefore women with childcare responsibilities are less likely to feel eligible for an award and/or have the time to complete the application form.

Although the consultants interviewed did not specify their age, it could also be hypothesised that the older a consultant is, the more likely they are to apply for a CEA and be successful. Firstly, because they are more likely to have children who are less dependent on them and thus they have less childcare responsibilities so can show they are going “over and above” their role. Secondly, they will most likely have more experience of self-nominating for the awards, or know of the experiences of those that have been successful. In addition, it should be noted that the state has significantly reduced the number of new awards available to consultants so competition is higher amongst consultants who have never applied for an award. Therefore those already in receipt of awards, who are senior male consultants, can simply apply to renew their current award and are consequently more likely to receive an award compared to
those competing for fewer, new awards. Arguably, this means that as more women now begin enter consultant level posts, there is less chance of them receiving a CEA.

Economic austerity and the feeling amongst consultants that the NHS is in crisis also seems to be having an impact on those who decide to apply for CEAs, regardless of gender. There was evidence from the interviews that consultants and their colleagues felt as though they should not apply for CEAs whilst the government is making cuts to other health professionals’ pay and healthcare services. A consultant paediatrician referred to consultants with a “strong moral code” (Male consultant paediatrician, Interview 33) not feeling able to justify applying for additional money whilst the “NHS is going through a hard time” (Male consultant paediatrician, Interview 33). In addition, the state has reduced the number of new awards available and CEA amounts have been frozen, despite recent annual DDRB recommendations in July 2018 suggesting CEAs should increase by 2% to align with a recommended 2% basic pay rise for consultants. Again, this means in the future there will be fewer awards available of a lower amount for those entering consultant level, most of whom are women.

Overall, it appears there are three key gendered issues surrounding the unfair allocation of CEAs. Firstly the self-nomination processes, secondly, the subjectivity surrounding the criterion that is used and thirdly around the emphasis on time spent in work. Both the process of applying for an award and the subjectivity surrounding them is clearly having negative consequences towards female consultants. There is no evidence from the interviews or secondary data available to suggest that this is an intended consequence of the awards process, or that female consultants are being discriminated against at allocation stage when the panel decides who receives an award. However, the interview data does show evidence that the actions of the NHS as the employer are having a gendered effect, either unintentionally or not, as the embedded criterion are difficult to reconcile with care responsibilities. In addition, there also appears to be little mention of support mechanisms in place for consultants applying for awards. Perhaps this is another issue why a high number of consultants feel discouraged to apply for the first time.
CEAs could be argued that this is the state’s way of being seen as the ‘model employer’ (Hyman 2008; Coffey and Thornley, 2009) by providing, in some cases, very generous pay awards for excellent performance, as an incentive to motivate consultants and recognises top quality consultants. However, the findings show that many consultants, particularly women, do not apply when they may be deserving of an award. Therefore, it could be argued that there are contradictions in this approach to pay. Firstly, it could be argued to be an attempt by the state to encourage more doctors to work longer hours for less pay in some cases since not all consultants receive an award. Last year, 54% of consultants in England and Wales received an award (Lintern, 2017). It is also an approach to pay that shows attempts to promote a higher standard of healthcare, although it places the onus on consultants acting in a cost-effective manner and working more hours than they are contracted to in order to achieve the highest standard of care, which are ideas more aligned to NPM cost-cutting ideologies.

GPS’ PAY

GPs are unable to apply for CEAs, unless they are working within an academic post. Therefore, the way GPs can earn additional payment within the NHS is by becoming a GP Partner and running their own GP Practice. As mentioned in the previous section, women are less likely to enter GP Partnership roles. Also, female salaried GPs are more likely to work part-time. This may be related to the shorter GP training programme, as salaried GPs can earn higher salaries sooner at earlier stage of their careers, compared to their hospital-based specialty peers. Therefore working part-time at salaried GP level, most likely during a time in women’s lives when they have young children, is less financially problematic. Overall, the high number of female salaried GPs and high number of male GP Partners is likely to contribute to a gender pay gap in general practice.

PERCEPTIONS OF CHANGES TO THE MEDICAL PROFESSION

Consultants and GPs were chosen as a group to include in the research sample partly because it was expected that they would have first-hand experience of the medical profession changing to consist of more female doctors. As noted in the literature review, there has been much criticism in the media with claims that the increase in
female doctors is damaging to the NHS since they are more likely to work part-time and take time out to have a baby, thus increasing staff shortages. The interview questions set out to find out whether consultants shared these views, and to see how they feel the medical profession has changed.

All consultants and GPs interviewed said they felt more women in the medical profession was positive, and most said the increase in female doctors creates a more diverse workforce that is more representative of the patient demographic. Several also commented that the professional status has changed, with a female consultant anaesthetist commenting:

“20 to 30 years ago medicine was seen as a real status profession, whereas now it is more of a caring profession. If you go into medicine now expecting status, you are very wrong” (Female consultant anaesthetist, interview 32).

However, interview respondents did not make the direct link that the status of medicine is changing due solely to more women entering the profession, as interview respondents felt that generally the ‘doctor knows best’ form of practising medicine is dying out due to a generational shift in values. The interview data also shows that interview respondents working in their ‘destination roles’ feel that specialty trainees place more importance on achieving a work life balance and work fewer hours compared to the 90-100 hours per week they say they worked:

“[Specialty trainees’] hours don’t tend to be as long as ours’ were. At the start of my career I worked 48-hour shifts. Then during my training I did 24 hour shifts, and in the first few years as a consultant. Now we’ve dropped to 12 hours...so I think it’s easier now, as a trainee, from that point of view” (Male consultant anaesthetist, interview 35).

Some interview respondents, particularly the Training Programme Directors, stated that better workforce planning needs to accommodate this general shift in attitudes towards working time, as there are frequently gaps on the rota.
CONCLUSION

Overall this chapter shows that there are gendered experiences of employment for both consultants and qualified GPs, where the ability to work excessive hours consequently affects pay. Consultants’ working time is more manageable after training so many work full-time hours, including women. However GPs feel their working hours are still intense and long post-training, and only manageable by working part-time hours. Therefore there appears to be a disconnect between prospective specialty trainees’ views of the working hours within a specialty compared to the reality of working hours in the specialty’s ‘destination role’. Similarly to specialty trainees, working time also impacts on the career progression prospects, and subsequently higher pay, for female consultants and GPs. Female consultants are less likely to receive CEAs because of the emphasis on working ‘over and above’ already long working hours during a time where they are likely to have young children, and female GPs are less likely to want to commit to a GP Partnership role as there are more workload pressures and fewer maternity benefits. Therefore this contributes to the gender pay gap seen in medicine. There also appears to be a view amongst consultants and GPs that the way medicine is practised is changing towards a less paternalistic model and more collaborative approach with patients to care. Meanwhile they also feel there is a generational shift with attitudes to working time, where specialty trainees and younger consultants place more importance on achieving a work life balance.
CHAPTER EIGHT
DISCUSSION

INTRODUCTION
This discussion chapter links the findings presented in the previous three chapters to the literature review themes raised in chapter two, in order to address the four research questions. The discussion focuses on the contributions of the findings both in adding to the existing literature and in identifying potential practical policy recommendations to address emerging problems.

Four key interlinking areas of literature emerge in the literature review (chapter two), which are described again briefly here before the discussion. The first concerns gender segregation and the feminisation of male-dominated professions. The literature in this area shows that gender segregation re-emerges, albeit in a different form, when women enter male-dominated professions as they tend to become both horizontally and vertically segregated, working in the lower paid and/or lower status areas of the profession, and at the lower paid and levels of the organisation hierarchy (Reskin and Roos, 1990; Crompton and Sanderson, 1990). The second area of literature focuses on the theory of devaluation, which argues that once women enter male-dominated occupations/profession, they become devalued in terms of pay, status and job security. The third area of literature concerns working time and, more specifically, working time in professions. There has been the simultaneous increase of women in the labour market and move towards a results-based model of working time (Fleetwood, 2007; Rubery et al, 2005a). At the same time, changing attitudes towards equality of opportunity and inclusion have focused attention on the need to provide more supportive working time regimes, but these accommodations coexist with changes to working time to the benefit to the employer (Fleetwood, 2007; Özbilgin et al, 2011). Staying with the theme of working time, the literature review (chapter two) also discusses the working time within professions. Professionals work long, paid hours but also many unpaid, additional working hours (Bolton and Muzio, 2008; Lewis, 2007; Conley and Jenkins, 2011). As a result, many female professionals have little option but to work part-time hours, which has negative consequences on their career progression.
and, subsequently, their pay (Walsh, 2012; Durbin and Tomlinson, 2010). In addition, the literature shows that women entering male-dominated professions can have an impact on attitudes towards working time, whereby employees of both genders strive to achieve a better work life balance (Gatrell, 2004).

The fourth area of literature surrounds the state’s numerous roles as the employer of a predominantly female workforce and how the actions of the state in its other roles influence and shape the working lives of public sector workers, in terms of their pay, work life balance, equity and career choices. The state has a conflicting role as the employer (Hyman, 2008; Coffey and Thornley, 2009), between being the ‘model employer’ whilst controlling public spending, which can thwart attempts to truly achieve its ‘model employer’ objective. During a period of economic austerity, it can be seen that the state attempts to produce more at a lesser cost, thus leading to reductions and freezes to pay, work intensification due to limited resources and, in some cases, job losses - in turn, devaluing public sector work (Bach, 2016; Cribb et al, 2014). In addition, the state is also required to meet its public sector equality duty to ensure both public sector workers and users are treated fairly and equally. Again, in times of economic austerity, the state’s commitment to cutting costs and meeting strict budgets predominates its public sector equality duty (Conley and Page, 2018).

Even though research has found that women working in the public sector tend to earn more compared to their private sector counterparts (Lucifora and Meurs, 2006) there is a tendency for female-dominated professions within the public sector to become devalued and this degradation and undervaluation of women’s work in the public sector tends to become exacerbated when women work part time hours (Lane, 2004; Conley and Jenkins, 2011; Thornley, 2007; Healey et al, 2011).

As indicated in earlier chapters, these areas of literature set up a number of questions about how the increase of women might be reshaping the medical profession:

**Research question one:** How is gender segregation being produced in the medical profession, and what are the key factors in shaping this gender segregation?
Research question two: Has the feminisation of the medical profession led to the devaluation of the profession, and/or areas of the profession, in terms of professional status, pay and job security?

Research question three: How has working time shaped the employment experiences of doctors, within the context of a feminising workforce, and to what extent has a feminising workforce shaped attitudes, and responses, towards working time arrangements within the medical profession?

Research question four: What are the roles of the state, and other institutions with influence over the employment relationship, in shaping the employment experiences of doctors within a feminising workforce?

In order to address all of the research questions in the very specific but complex context of the medical profession in NHS England, the research concentrates on the broader areas of working time, pay, careers, and the status of medicine. The three findings chapters provide rich data to address these issues at three key points across the typical medical career trajectory, as highlighted in Table 9 below. These findings chapters first of all explored specialty trainees’ medical specialty choices; second considered specialty trainees’ employment experiences once they are carrying out their training; and thirdly explored how consultants/qualified GPs experience employment within the NHS once they have reached their ‘destination job’.
Table 9: Outline of empirical chapters

<table>
<thead>
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<th>Focus</th>
<th>Chapter Five</th>
<th>Chapter Six</th>
<th>Chapter Seven</th>
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<tr>
<td>Reasons for medical specialty choices – are career choices gendered?</td>
<td>Employment experiences – in terms of working time, careers, pay and status</td>
<td>Employment experiences – in terms of working time, careers, pay and status</td>
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</tr>
<tr>
<td>Career Stage</td>
<td>Specialty trainee</td>
<td>Specialty Trainee</td>
<td>Consultant Salaried GP GP Partner</td>
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Although discussed in more detail in the context chapter (chapter three), it is important to briefly highlight the main contextual issues relating to the key themes that have been unfolding during this research. Prior to the research, it was already well known that contextually the medical profession is both complex and unique among professions since it is an elite profession under the monopsony of the NHS as the employer of the vast majority of hospital doctors in the UK – and the provider of contracts to the self-employed GPs. The main contextual issue relates to the state’s role as the employer of doctors, whilst also having responsibility for public spending and providing a public service. During the time of this research there were two key state interventions. The first was the continuity of economic austerity measures in the NHS. The second were radical changes to the junior doctors contract. The state’s actions during this time raise further questions, which this chapter identifies, and provides insight into, under each of the broad themes to emerge from the research.

For purposes of the discussion, the state is identified as operating as the DH (in shaping employment terms and conditions) and HEE (in shaping the training and employment programmes). They are separate from the Royal College (in shaping the knowledge base and examination requirements), and BMA (in its role in negotiating the contractual conditions with the employer), who may work together to resist some
of the state’s interventions. Thus the medical profession is regulated through a multifaceted employment relationship that changes at various stages of the medical career trajectory.

GENDER SEGREGATION

In this section the key issues raised by the literature are discussed in turn, with the aim of addressing the reasons for medical specialty gender segregation. Medicine is a unique context to look at gender segregation because it is the university medical schools that are effectively determining the number of women being recruited into the profession. Thus supporting Reskin and Roos’ (1990) dual-queue process research, as this means there is a greater supply of women and a smaller supply of men in the labour queue for the employer to choose from once more women have qualified from medical school. Therefore this also reduces the employer’s discretion over who to employ after medical training is completed, because the universities have already determined the labour queue. However, the purpose of this research was not to look at why the medical profession is experiencing feminisation but to look at how feminisation is shaping the medical profession, particularly in terms of medical specialty choices. This research finds women tend to opt for medical specialties that appear to be more compatible with a family life and avoid the most extreme forms of working time, thus causing the horizontal gender segregation across medical specialties.

Bolton and Muzio (2008) argue that it is men within male-dominated professions that put in place “defence mechanisms” to prevent women from entering more prestigious areas of a profession to maintain the high status of the profession. The findings from this research do not indicate that men within the medical profession have overtly used defence mechanisms to purposefully block out women from certain medical specialties, to retain high levels of professionalism. It appears that the organisation of the medical labour market, mainly by the state and Royal Colleges, is the key shaper of gendered medical specialty choices. For example, more women are attracted to general practice because of the availability of LTFT training, geographic stability, and fewer unsocial working hours. Therefore, perhaps in the case of medicine, the term
“diversionary pathways” would be more appropriate than “defence mechanisms” (Bolton and Muzio, 2008) to describe how the actions (and inaction) of the state and Royal Colleges have created medical specialties that are more attractive to female doctors and thus diverted them towards certain medical specialties and career paths.

The findings also show that female consultants are less likely than men to apply for CEAs, to achieve additional bonus payments, because the extreme male breadwinner / results based model of working time prevents them going ‘above and beyond’ their excessive workload whilst they are also trying to balance family life. This is similar to performance related pay seen in the legal profession, whereby solicitors are required to entertain clients during unsocial hours to reach their targets and gain bonus pay. Performance related pay for doctors was introduced at the time the NHS was formed in 1948 when doctors were primarily male as a means of retaining consultants and to deter them from leaving the NHS to work in private practice where the pay is more lucrative. However, despite changes introduced to ‘modernise’ the scheme in 2003/4, and an increase in female consultants, women in medicine face similar challenges to female lawyers, when receiving additional payments. The requirement to work more hours in addition to already extreme working hours to achieve pay bonuses is an example of a “defence mechanism” (Bolton and Muzio, 2008) that prevents female consultants from earning higher levels of pay, albeit again this is not explicitly done in medicine.

This research also provides evidence to challenge Elston’s (2009) framework that shows reasons for gendered medical specialty choices (see Figure 3, page 54). Although Elston (2009) recognises that organisational change can shift medical specialties across the quadrants, this research provides evidence that other aspects of employment are more important drivers for gendered medical specialty choices than the drivers Elston (2009) has chosen to use. For example, unlike Elston (2009), this research does not find strong evidence that use of technology was main determinant of men opting to specialise in anaesthetics. The findings of this research agree with Elston (2009) that women are more likely to seek “plannable” working hours. However it appears that a high availability and accommodation of LTFT working hours, in
comparison to other medical specialties, is an aspect of working time that is the key driver in women’s medical specialty choices across all three specialties included in this research. The researcher considers both the availability and accommodation of LTFT, referring to availability in terms of the staffing levels in the specialty (in that higher staffing levels equates to a higher availability of LTFT working) and accommodation as whether the specialty culture is accommodating of LTFT working (in that specialty cultures that are more understanding of WLB issues would accommodate LTFT working). The organisation of training programmes also shows to create gendered reasons for medical specialty choices in the research findings, as women were attracted to run-through training programmes (paediatrics and general practice) to allow for greater job security when taking time out of specialty training to have children. Although the availability, and accommodation, of LTFT working is found to be the main reason for women choosing the three specialties included within this research. Therefore the researcher has developed a new framework to show why certain medical specialties are, and are not, feminised, as well as why certain medical specialties are currently experiencing feminisation at a greater rate than others. Figure 10 below illustrates these ideas through a new theoretical framework.
The framework argues that medical specialties that can be placed in the quadrant of run-through training and high availability, and accommodation, of LTFT training are the most attractive medical specialties for women. However, medical specialties that can be placed in the quadrant of uncoupled training and low availability, and accommodation, of LTFT training are the least attractive medical specialties for women (for example, surgical specialties\textsuperscript{15}). The framework argues that those specialties that lie within the quadrant of uncoupled training and high availability, and accommodation, of LTFT training are beginning to feminise at a greater rate than other medical specialties, for example anaesthetics. This research provides evidence that

\textsuperscript{15} Surgical specialties have been placed within this quadrant as the literature review chapter provides evidence that surgical specialties are likely to not be as accommodating to LTFT working hours compared to other specialties. For example, just 3% of surgical trainees work LTFT hours (GMC, 2017b). Thus explaining why the specialty is heavily male-dominated.
anaesthetics is seen as a specialty that is “forward thinking” and accommodating of LTFT training now more women are entering the medical profession, so more women have consequently been attracted to the specialty. The researcher predicts that the current male-dominated specialty of emergency medicine may see a greater increase of women choosing the specialty in the coming years, as the specialty has shown signs of beginning to recognise the need to accommodate LTFT training. The junior doctors’ contract negotiations highlighted to HEE that emergency medicine required more flexible working time arrangements to prevent burnout, increase morale and improve recruitment. Although their plans to improve recruitment are not gender specific, it could be argued as women are now the majority of medical students, that steps need to be taken to attract more women, as well as men, to the specialty. Therefore in 2018 emergency medicine ran a successful pilot to add an additional third category of ‘lifestyle reasons’ to the criterion to apply for LTFT training. The researcher argues the additional category may create a culture that is more accommodating of LTFT training, thus attracting more women to the specialty.

When the three medical specialties of anaesthetics, general practice and paediatrics were identified, it was an open question of what the researcher might find in terms of reasons for medical specialty choices. However this framework identifies there are similarities between the three specialties, so further research is required to distinguish what is happening in the other quadrants of the framework (for example, the quadrant of run-through training with low availability, and accommodation, of LTFT training). However the researcher predicts this quadrant would contain medical specialties that are preferred by men, as the accommodation and availability of LTFT training appears to be of greater importance to women compared to the organisation of the training programme.

**THEORY OF DEVALUATION**

One of the most prevalent arguments within the literature regarding feminising professions is the ‘theory of devaluation’ (Ackroyd and Muzio, 2007; Edwards, 2003; England, 1992; Reskin and Roos, 1990; Mandel, 2013), which argues professions become devalued in terms of pay, status and job security once more women enter.
This research provides evidence to support the theory of devaluation in medicine. However in the case of medicine, the findings show that devaluation occurs in varying degrees depending on whether it is the entire medical profession being discussed; or by medical specialty; or by hierarchical level. It may be the case that the profession being bound to the public sector has had an impact on the way the profession has experienced devaluation. New Public Management literature suggests that an adoption of a more business-oriented approach to the management of public services has the tendency to downgrade public sector professions, due to the lowering of pay to meet strict budgets and work intensification due to fewer resources (Corby and White, 1999; Bach, 2002; 2016; Bottery, 1996; Hood, 1991). The findings show that the changes to the junior doctors’ contract is an example of how the state has used New Public Management strategies under the guise to meet the interests of NHS consumers (the electorate). For example, framing the changes to the junior doctors’ contract as necessary to increase patient safety during the weekends could be argued to be a means for the state to cut junior doctors’ premium pay hours and reduce salary costs. In addition, research by Meacock et al (2016) indicates that the state’s statistics to justify a ‘seven-day NHS’ were flawed, and also the state’s actions of reducing unsocial hours pay premiums. Moreover, the state’s actions of reporting that the lack of doctors at work during the weekends causes increased death rates during the weekends could be an attempt to devalue the public’s perceptions of the medical profession in terms of the profession’s “commitment to...the promotion of the public good” (Cruess et al, 2004, page 75). As a result, the state’s actions could break down the “social contract” between the medical profession and society, which “in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation” (Cruess et al, 2004, page 75), thus devaluing the profession’s status.

Secondly, looking at devaluation across medicine’s hierarchy, it appears that the more immediate signs of devaluation have been seen at the lower levels of medicine’s hierarchy, where the majority of female doctors work, compared to consultant level. This difference is due to the changes to the junior doctors’ contract, highlighted earlier in this chapter, that has diminished terms and conditions by increasing unsocial...
working hours and decreasing unsocial hours’ pay. Although consultants’ contracts are currently under review, no proposed changes have yet been made. It may be the case that as more women enter consultant posts, long-negotiated changes to consultant contracts will eventually take place. Exworthy et al (2016) argue that consultants have remained relatively immune from changes to their pay, and a number of specialty trainee respondents in this research commented that they felt the government was targeting junior doctors as an “easy option” due to more women working at that level. This discussion also prompts questions surrounding the future of CEAs. The findings from this research, and others (Abel and Esmail, 2006), do show that CEAs create gendered pay inequality amongst consultants. The Department of Health proposed that CEAs are to be scrapped altogether under the guise of saving money. However the BMA took legal action, and saved consultants’ rights to receive CEAs, for the time being, as they are seen as contractual (BMA, 2018). However, the DH has frozen CEA payment amounts despite the DDRB recommending that award amounts should be increased by 2% inline with a 2% pay rise of consultants’ basic pay. The original version of CEAs, known then as Distinction Awards, was introduced to attract doctors to work in the NHS. If they are removed, it may be that consultants increasingly move into lucrative private practice to earn similar salaries. However, as seen at other points during the NHS’ history (such as the changes to consultant contracts during the New Labour government favouring doctors), consultants have again used their strong bargaining power because they are aware the NHS cannot function without them. This finding highlights the continuing tension between doctors and the state that has been present since the formation of the NHS in 1948, where doctors strive for clinical freedom and greater financial reward whilst the state attempts to reduce public spending. Therefore, doctors’ strong bargaining power could lessen the impact of devaluation, as seen in the junior doctors’ contract negotiations and the failed attempt by the state to end CEAs.

The findings also show that medicine as a profession is changing towards a less paternalistic, “doctor knows best” relationship with patients. There is also evidence that the recruitment process is based more on having good communication skills with patients, particularly in general practice. It is also felt by doctors that the introduction
of revalidation, where doctors have to revalidate their licence to practice every year, post specialty training, lessens doctors’ autonomy and consequently lowers the profession’s status. Whether some of these changes, such as the changes to the doctor-patient relationship and the recruitment process are due to more women entering the profession, or whether this change has attracted more women into the profession is not known for certain, but there is the perception amongst doctors that the public’s view of the profession, and consequently status, is lowering and associated with notions of caring and nurturing rather than ‘doctor knows best’.

WORKING TIME
Working time issues are of central importance in facilitating the equal treatment of women entering primarily male-dominated to mixed or feminised professions. The literature review identified two key trends that could underpin the equal treatment of men and women. The first concerns the move away from a standard, contracted hours model towards a ‘results-based’ model of working time that tends to suit the needs of the employer (Rubery et al, 2005a; Fleetwood, 2007). The second concerns the increased demand for work life balance/flexible working, particularly as more women are entering the labour market. Furthermore, there is a trend towards more men seeking part-time employment for childcare reasons as well (Gatrell, 2004). Although part-time working hours can enable employees to balance work and family life, the pressures for long working hours are pervasive and when workers seek shorter or more flexible hours they may face loss of career opportunities and status (Crompton and Lyonette, 2010). This PhD research shows how both of these trends underpin equality and, in the case of medicine, the detrimental impacts of extreme working hours and working part-time in this professional context can be considered even more extreme.

The findings show that doctors across all levels, and of both genders, are still working long hours in comparison to most jobs and professions. Although the hours are shorter than before they still fit more the traditions of medicine’s male-dominated workforce, where it is expected that men will be the sole, or main, earners of the household, freed from care responsibilities, than working time patterns compatible with having
some care responsibilities and/or a personal life. The working time patterns for specialty trainees in full-time work can be considered a kind of hybrid model; they do still receive a pay premium for unsocial hours work but all respondents were found to be continuously working above and beyond their scheduled working hours for no additional payment, for example, to finish the tasks of that day; and to carry out additional work for their own training and career advancement. The introduction of the new junior doctors’ contract adds a new dynamic to working time within medicine, as it encourages hospitals to increase unsocial hours working for no pay premium. In addition, the introduction of ‘guardians of safe working hours’ puts the responsibility onto doctors to monitor any breaches of the EWTD that limit weekly working hours to 48 hours per week, in shift patterns that remains to encourage aspects of the standard time-based model.

The findings also show that excessive working hours in medicine heavily shapes women’s employment experiences, and career and family decision-making. There is evidence that shows many female doctors, across all levels, make decisions to avoid the negative impacts of this hybrid model of working time, as it is not compatible with achieving a quality work life balance. One example of how women adapt their careers to this model of working time is by choosing certain medical specialties and career options that they deem to be more conducive with achieving a work life balance, such as female GPs not opting for more highly paid GP Partnership roles. This can also be seen in both the questionnaire and interview data with specialty trainees, where women choose general practice as this requires limited unsocial working hours and provides more geographical stability compared to hospital-based specialties. Similarly, the findings show women choose paediatrics because of senior role models who are seemingly able to achieve a good work life balance whilst working in a consultant post. Likewise, over 60% of female anaesthetics trainees surveyed chose anaesthetics as they felt they could achieve a good work life balance as the specialty is accommodating of LTFT training, partly due to the shift patterns brought about by the EWTD suit the nature of work, as there is less need for continuity of care with patients.
It should also be noted that this research reinforces the importance of not generalising when looking at the medical profession as a whole, as it can be seen from the findings that working time, and the controllability of working time, varies by medical specialty and also the stage of the medical career. Crompton and Lyonette (2010, page 240) argue that general practice is a “family-friendly professional niche” within medicine and that both consultant and GPs have more controllable working hours after qualifying from specialty training. However this research contradicts Crompton and Lyonette’s (2010) findings, and finds that general practice is not necessarily the “family-friendly professional niche” it is perceived to be, particularly at partner level, and that there are differences in working time within the medical profession dependent on gender, medical specialty and/or career level that determine how doctors experience working time. For example, the majority of hospital-based specialty trainees from anaesthetics and paediatrics have little control over their working hours, place of work and annual leave, since they work over their scheduled working hours; conduct additional work which contributes towards completing their training programme; rotate their place of work every six months; and often have fixed annual leave, or are expected to arrange cover for their annual leave themselves. In contrast, specialty trainees in general practice appear to have more control over their working time since they do not work unsocial hours during nights and weekends, and their place of work is fixed during the majority of their training programme (apart from a six-month hospital placement).

At the next stage of the medical career trajectory, the findings show that consultants have more control over their working time compared to specialty trainees. Although they are still working excessively long hours, there appears to be more flexibility around hours worked as seniority increases, a finding in line with Crompton and Lyonette’s (2010) findings that senior doctors have more control of their working hours. However, salaried GPs and GP Partners report the contrary that although they work fewer unsocial hours, they find it difficult to sustain their working hours due to the high intensity of the work, mostly due to shorter ten-minute appointments, decreasing GP numbers and increasing numbers of patients. Moreover the morning and evening surgeries mean that the hours are also far from family-friendly. Therefore
it appears from the findings of this research that there is a trade-off between the number of years it takes to complete hospital based and community based specialty training, and future working time once training is completed and doctors are working in their ‘destination jobs’. It should also be noted that as well as choosing certain medical specialties, specialty trainees of both genders said they had responded, or considered responding, to the extreme nature of the working hours by taking time out to complete research, a postgraduate degree or carry out work experience abroad. The introduction of the new junior doctors’ contract makes these options more difficult for women with children, or planning to have children, in terms of pay due to the abolition of annual pay increments, although this effect was mitigated by the strategy of the BMA to negotiate to reduce the number of pay increments from five to just four. Thus more junior doctors will reach the top of the scale earlier, so doctors taking time out once they’ve reached the top pay increment will not be disadvantaged by this decision. However, the most notable mechanism that women use to achieve work life balance within these excessive working time conditions during specialty training is by working within medical specialties that are deemed to be more ‘family-friendly’ and/or work ‘part-time’ hours, referred to as LTFT in medicine.

**LTFT working hours – ‘the full-time part-timer’**

Before discussing LTFT working within medicine, it is necessary again to consider what working full-time entails in medicine. When working hours do become shorter as a result of LTFT training, the overall working hours remain long relative to most part-time work in other professions/occupations. Even though LTFT training is specifically provided to enable a better work-life, they still require working hours that are more in line with the standard UK full-time working hours. For example, 60% of full-time hours plus 50% of on call amounts to scheduled work of around 28 hours, if full-timers are working the maximum 48 hours per week, and with unscheduled extensions plus work at home, working hours could easily exceed 30 hours per week, not that far below the average weekly full-time working hours in the UK of 36.9 hours per week (ONS, 2018b). This makes medicine a complex context to compare with other professions and occupations within current academic literature, and due to medicine having such an extreme model of working time, on a practical level, it does indicate that there is
considerable opportunity for changes to be made in working time in response to the feminisation of medicine.

Data from the National Training Survey (GMC, 2017b) shows the number of LTFT specialty trainees is increasing, but LTFT trainees still account for less than half of specialty trainees across all medical specialties. The findings from this research shows that most specialty trainee mothers have to work LTFT because the working hours are already long, and many specialty trainees plan to work LTFT in the future as they expect maintaining the levels of full-time working impossible for a prolonged period of time. Similarly, at salaried GP and GP partner level – all of the female respondents worked part-time hours. Although working hours were deemed to be more controllable at consultant level, so the respondents’ need for part-time work was reported as less. However, potential trends towards high levels of part time working amongst women in medicine maybe because the hybrid model of working time found within medicine combining long scheduled hours with results based working on a full-time basis is not conducive to family life. However, this research also found that LTFT doctors also stayed later than their scheduled hours and conducted additional work for training purposes.

At the same time, LFTF work is still based on the standard time-based model as LTFT work is often calculated as a job share with another LTFT doctor. Therefore days and hours worked usually remain the same, in part so doctors can make childcare arrangements. As mentioned earlier, Fleetwood (2007) describes job sharing as an employee-friendly option of flexible working, and this research does support that as LTFT mothers commented that job sharing did enable them to balance work and family life, on the whole; and female paediatric trainees were drawn to the specialty because of the ability to job share at consultant level. This form of flexible working effectively maintains the standard full-time model from a workforce planning perspective and part-time working is not available to employers as a means of adjusting staffing to meet variations in demand, as is the case when part-time work is organised solely in the interests of employer flexibility (Fleetwood 2007).
However, the dominance of the job share model has a negative knock-on effect for doctors as the number of pro rata full-time hours LTFT doctors can work to suit job-sharing are very rigid (usually 60% of full-time scheduled hours) along with the expectation to still work within an increasingly results-based model, essentially out of goodwill. This applies even in contexts of overall staff shortages, although the intensity of these shortages is leading to some increased flexibility according to an interview with a BMA official. The outcome of this rigidity is that LTFT doctors are earning less, on the basis they are working less than full-time, but they are still work longer than their paid hours for no additional remuneration. This issue arose in the interviews, and discouraged some mothers from shifting to LTFT working hours because it was not financially feasible as a trade off with the actual non-working hours they would achieve by working the rigid pro-rated working hours LTFT offers. Similarly, many mother respondents felt they were disadvantaged by the set LTFT working hours because they could only complete the essential additional work required for their training programme and subsequent career progression outside scheduled hours, which was often difficult due to care responsibilities. Thus when some form of work life balance is achieved, it may be at the detriment of doctors’ careers and pay. Interestingly, the opposite situation occurs at the higher levels of the career hierarchy, since men are more likely to work part-time when in a consultant post, this may be so they can also work in private practice where pay is more lucrative.

Referring back to the third research question: *how has working time shaped the employment experiences within the context of a feminising workforce, and to what extent has a feminising workforce shaped attitudes, and responses, towards working time arrangements within the medical profession?* From the findings, it does not appear that the medical profession, as a whole, has moved away from its traditional extreme male breadwinner model to accommodate the increasing numbers of women entering medicine, even though the EWTD has reduced the average length of trainee hours. As highlighted above, this can be seen at all key stages of the career trajectory researched and across all three medical specialties. There is the expectation that specialty trainees will conduct additional work outside of their scheduled clinical working hours, in order to complete their training programme. For example, the
findings show that hospital-based trainees complete further extra work to enhance their CV to improve their chances of gaining a consultant post after completing their training.

Working time pressures manifest themselves in different ways in the destination jobs of consultants and GPs. Consultants are expected to conduct additional work outside of their scheduled clinical hours in order to successfully apply for and receive CEAs to increase their annual salary; as a consequence fewer female consultants are found to be applying for or rewarded CEAs. The findings also show that female GPs, and increasing numbers of male GPs, respond to the pressures by often opting to work part-time and being less likely to accept partnership roles due to the working time pressures. Therefore this extreme model of working time does not only have an impact on work life balance, but also on career choices, career progression and subsequently pay. Since it is women that usually implement these navigation techniques to avoid the most extreme cases of working time in medicine, this causes them to become segregated into certain medical specialties that are perceived as less prestigious and less likely to be able complete additional work in order to see pay increases and other career opportunities, such as research.

These working time arrangements arise out of a number of pressures and factors as highlighted in Figure 11 below. On the one hand there are the Royal Colleges and Health Education England (HEE) regions that are responsible for establishing and protecting training standards and on the other there is the state, NHS employers and the BMA who negotiate terms and condition, including working time. The actions of these actors interact to shape the working time arrangements implemented by Local Employers and consequently determine doctors’ experiences.
The state as the employer, budget holder and service provider has also played a role. For example, the introduction of the EWTD has restricted scheduled working hours to a maximum of 48 hours per week on average, moving away from the norm of doctors working continuously in the hospital/GP surgery for on average of 90-100 hours per week prior to the legislation (Bowhay, 2008). On the other hand, the recent changes to the junior doctors’ contract could see the potential increase of unsocial hours working, particularly during the weekends\textsuperscript{16}, which may also lead to increased levels of burnout and a reduction in morale across doctors (Beesa et al, 2016). The other roles of the state in the employment conditions and experiences of doctors are discussed in the next section.

**ROLES OF THE STATE**

Prior to the data collection, it was expected that the state might play a role in the way feminisation is shaping the medical profession, since medicine in England is largely bound to the NHS. Thus the state is effectively the employer of doctors. This led to the fourth research question to be raised: *what are the roles of the state, and other*

\textsuperscript{16} The full extent of whether the junior doctors’ contract has led to increased unsocial hours working hours is not yet known due to staff shortages.
institutions with influence over the employment relationship, in shaping the employment experiences of doctors within a feminising workforce? It can be seen from the previous sections in this discussion that the state has only made a partial response to its feminising workforce in terms of amending its extreme model of working time, mainly through providing for LTFT working for care reasons, while maintaining many elements of the male breadwinner oriented extreme working time model. Higher levels of state response may have been expected due to the high levels of women entering the profession and the importance of retaining medical professionals within a context of staff shortages. However, as the monopsonist employer of doctors, it may be the case that the state does not need to respond to the issues affecting female doctors as they have few alternative career opportunities having invested a large amount of time and money into their medical training. It could be argued that the state, in its actions as exemplified by the junior doctors’ strike, may be taking advantage of the feminising workforce to reduce pay. This discussion now leads to the role of the state within these processes, as the findings show this is an interlinking theme that connects both the extreme working time arrangements and devaluation within the profession.

As highlighted in the literature review (chapter two) the state has traditionally striven to be perceived as a ‘model employer’ by implementing policies and practices that are deemed as fair, and inclusive. While there has been less of a focus on this role over recent years, with the public and political debate focused more on how public sector workers are allegedly overprotected due to the lack of market discipline, this requirement to consider fairness and equality has been strengthened in principle by the equality duties for public sector organisation. However, it is still the case that during times of austerity and cost saving, capitalist logic can be expected to prevail regardless of a potential negative impact on employees (Hyman 2008; Coffey and Thornley, 2009). Hyman (2008, page 264) argues that the state has multiple roles, as well as being an “employer in its own right” of public sector jobs, the state has six other roles that shape national employment relations. These are:

1. procedural regulator;
2. legislator of employment rights;
3. economic manager, through shaping the labour market and;
4. shaping the employability of the labour market;
5. shaping the welfare state; and
6. promoting social citizenship guidelines

This research supports Hyman’s (2008) and Coffey and Thornley’s (2009) argument, as there does appear to be a trade off between the state being the “model employer” and cutting costs. The NPM ideology that focuses on making public sector workers more responsive to markets, albeit in the case of public services these are pseudo markets, shows the importance of the state’s role of ‘shaping the welfare state’ (Hyman, 2008) through the delivery of public services. Due to the NHS being so politically charged, it is important for the state to be perceived by the public as delivering an excellent standard of healthcare service in order to win public votes in elections. The findings show evidence of where the state has attempted to be seen as the “model service provider”. A prime example of this is the Department of Health’s proposed changes to the junior doctors’ contract that was unfolding during the majority of the data collection process, in February to May 2016.

The first proposed new contract increased the number of unsocial hours junior doctors were required to work, whilst reducing the working hours classified as “unsocial” when doctors’ were paid a premium hourly rate. At the same time, automatic annual pay increments were also abolished, being replaced by a system where pay increments are based on officially completing a training year. Instead, the state offered a blanket 11% pay rise for all junior doctors, when in reality they were reducing pay elsewhere and indirectly penalising its female specialty trainees as a consequence. The introduction of a ‘7 day NHS’ could be an attempt to appear to the consumer that they were improving the health service and raising standards, because the state is not in a position explicitly to cut services and lower healthcare standards, and chose instead to make contract changes so that the workforce had to deliver more for less.

These motives of the state to implement a new junior doctors’ contract are linked to
the previous two discussion themes of working time and, feminisation and devaluation. In terms of working time, the state appears to aim to achieve two outcomes. First, by increasing unsocial hours work and thus changing what is classified as standard working time, the state is further entrenching the extreme male breadwinner model of working time and attempting to normalise unsocial working hours within the profession. The second outcome the state sought to achieve is saving costs, as premium pay for unsocial hours is reduced. The DDRB review of the contract in July 2015, chaired by Professor Paul Curran, argues the proposed contracts to reduce working time classified as unsocial hours “would bring junior doctors and consultants more in line with the other sectors...Some sectors do not pay a premium for working on Saturdays and this may be the area, in certain sectors, in which we will see further movement towards widening the definition of plain time in the future” (DDRB, 2016, page 13). In addition, the report also argues that doctors’ working hours and pay should align with other higher-paid professionals, for example: “other professionals that provide seven-day services such as police superintendents do not receive any unsocial hours payments: they are expected to work any necessary additional hours as part of their professional salary arrangements” (DDRB, 2016, page 50). However, the issue then becomes whether arguably junior doctors are paid at a higher, ‘professional’ level without banding and pay premiums for unsocial hours, since at the time of data collection, Foundation Year doctors start on a salary of £23,091.

Therefore the state’s actions support Rubery et al’s (2005a) and Fleetwood’s (2007) research that results-based, employer-friendly working time arrangements are becoming the norm. The state as the employer appears to be using a limited number of specialty trainees both intensively and extensively, which again adds to working time pressures and consequently the extreme male breadwinner/results-based model becomes further entrenched. In terms of feminisation and devaluation, the findings show that female specialty trainees were aware and concerned about the negative impact the proposed contracts would have on their employment terms and conditions. For example, the abolition of automatic annual pay increments towards a merit system where pay increments are awarded for successful completion of training stages disproportionately affected part-time specialty trainees who take longer to complete
their training and are more likely to be women with childcare responsibilities. In addition, the increase in unsocial hours pay for a decreased amount of remuneration would reduce resources to pay for childcare and increase hours at work during when attaining childcare provisions is more difficult. As the number of women entering the medical profession has been rising, women represent the majority of doctors at the trainee level where the changes have been proposed and implemented, albeit with some amendments. Therefore it would appear that the actions of the state are in these respects negatively shaping the employment experiences of doctors, particularly women. Despite the outcomes of the equality impact assessment (EIA) in March 2016, the state concluded the changes meet business needs. Again, this supports both Hyman’s (2008) argument that capitalist logic prevails over being the ‘model employer’ during times of austerity and arguments that New Public Management is often associated with the downgrading of public sector jobs, as pay is reduced to meet stricter ‘business-like’ budgets (Conley et al, 2011), particularly public sector jobs that are dominated by women, such as teaching (Conley and Jenkins, 2011). Moreover, it was the EHRC that suggested the EIA might breach the public sector equality duty (Section 149) and judicial review started before return to negotiating table, thus also supporting Conley’s (2012) argument that capitalist logic prevails over achieving equality, particularly during times of economic austerity (Conley and Page, 2018).

The interview data also highlights that there is a developing tension regarding the allocation of CEAs, and the state’s desire to meet a constrained budget. CEAs were originally introduced to encourage consultants to remain within the NHS rather than practise privately to receive a higher income. Surprisingly, CEAs costing £147m in 2016-17 (Lintern, 2017) have remained in place, and unchanged, throughout a seven-year period of austerity measures where specialty trainees have seen deductions to their pay and other professions within the NHS, such as nursing, have experienced pay freezes and caps. Although consultants have not seen an increase to the payment amounts of CEAs as recommended by the DDRB, it could be suggested that the upper level of the medical hierarchy is yet to see any major direct cuts to their pay linked with economic austerity compared to specialty trainees. Is this because consultants are seen as elite by the state? Or it could be argued that the state, as an employer, is
targeting austerity measures towards certain professions, and levels of professions that are dominated by women. Or, as mentioned earlier, perhaps consultants have a stronger bargaining power as they are the most qualified doctors and the NHS could not operate without them. The BMA (2018) has argued that CEAs are a legal entitlement for consultants as they form part of the employment contract, so at the moment the state is not in a legal position to abolish them. In addition, the state has conflicting roles of ensuring staff retention within the NHS and cutting costs, but some may consider that the state may be encouraging the demise of the NHS by using devaluation to help in privatising the health service. Although this cannot be said for certain at this stage, it is worth considering for future research whether there is a correlation between government public sector pay cuts and the level of feminisation of the profession or professional level experiencing pay deductions.

Furthermore, the reduction to GP appointment times to ten-minutes could be the state’s aim of being seen as the ‘model service provider’ to the general public, as by capping appointment times it could also be expected that patient waiting times are reduced – thus making the changes popular with the majority of the general public. This could be argued to be the state’s way of manipulating GP’s working time to increase the number of appointments, with fewer resources, for the same pay. However, this may have the effect of exacerbating the shortage of GP trainees and/or encouraging part-time working hours in this specialty due to the increased working time pressures linked to shorter appointment times.

This discussion leads to three further, broader questions that might be answered over a longer period of time as the profession becomes more feminised. The first is: do the state’s actions as the employer reflect the feminisation of the medical profession? This question is raised because only the junior doctors’ contract has faced immediate significant detrimental changes to working hours and pay whilst consultants’ contracts, including the CEAs that the findings show negatively impact female consultants, currently remain immune to any changes by the state. It could be argued that the state targeted the junior doctors’ contract as women represent more of the workforce at that level, whereas men continue to represent more of the workforce at consultant
level. The devaluation link will probably take a longer time to develop but following the research of Reskin and Roos (1990), Crompton and Sanderson (1990) and Bolton and Muzio (2008), the profession could be predicted to become segmented, less attractive to men and further devalued.

The second further question raised from this discussion is: what has the state done to reflect the changing medical workforce? The most notable step to regulate the extreme working hours in medicine is the introduction of the EWTD, which regulates working time. Although the UK government at the time was reluctant to implement it within the NHS, all countries within the EU are required to abide by it. The main regulation of the Directive that impacted doctors’ working time is Regulation 4(1) that states:

“a worker’s working time, including overtime, in any reference period which is applicable in his case shall not exceed an average of 48 hours for each seven days.”

It should be noted that the average working time of trainee doctors is calculated within the reference period of 26 weeks (6 months). This means that ‘on-call’ time also classifies as ‘working time’ if the worker is required to be available at the workplace or other place designated by the employer, even if the doctor is able to rest unless needed (Landeshauptstadt Kiel v Jaeger, 2003). The Directive also regulates rest periods of at least 11 consecutive hours in each 24-hour period of work (Regulation 10), and a limit of eight hours per night shift (Regulation 6). Although Regulation 4 (1) was not originally imposed upon doctors in training, the regulations were gradually applied to trainee doctors as a dramatic reduction was not feasible. From 1st August 2004 trainee doctors were allowed to work a maximum of 58 hours per week, decreasing to 56 hours per week by 2007 and finally to the latest reduction of a maximum 48 hours per week. The latest amendments to the EWTD aimed to change the long working hours and resident ‘on-call’ periods within the hospital; where a usual work schedule consisted of working “up to 12 hours, followed by a night on call and working the next day” (Bowhay 2008, p.1).
However, this research provides evidence that the vast majority of specialty trainees are working above and beyond their scheduled 48-hour week, if working full-time. In 2000, the state introduced nurse consultant posts so nurses could reach a top senior position within their profession, similarly to consultants in medicine. In addition, the introduction of nurse consultants was intended to take some of the working time pressures away from medical consultants. However is this, like the junior doctors’ contract changes, a way to achieve more for less? Is developing lower paid, non-medical staff to move into jobs similar to consultants devaluing the work of doctors who have dedicated years of their lives to intense medical training? Similarly, there have also been talks of nurses completing a degree in medicine on a part-time basis to qualify as GPs (Donnelly, 2017). This creates other routes into this elite status of medicine, and general practice in particular. Jeremy Hunt announced at the 2016 Conservative Party Conference that an additional 1500 doctors will be trained to alleviate the pressures of an understaffed workforce and to ensure the UK is “self sufficient in doctors by 2025”. During the conference, Hunt also proposed plans to train 5000 more GPs by 2020. More recently, five new medical schools in areas where there are staff shortages are due to open in September 2018 (Matthews-King, 2018). However, as seen throughout this research, training takes a considerable number of years since a medicine degree alone is five years in duration, without additional foundation and specialty training, so the impact of this would not be seen in the short term. It could also be argued that opening new medical schools in universities that have no, or limited, tradition in providing medical education, could change the perceptions and status of the profession.

The lack of immediate activity by the state raises the third further question: why has so little been done by the state to react to the increasing number of women entering the medical profession, particularly in terms of working time? The responses from the key actors within the employment relationship show that some progress has been made in alleviating the excessive working hours in medicine, but these are largely driven by the EWTD rather than the recent feminisation of the medical profession. However the findings from doctors show significant changes have not been made to reflect the working time needs of a predominantly female workforce. The findings suggest this is
for four main reasons. Firstly, Rubery et al (2005a) highlight the difficulties of reversing a results-based model of working time, which appears to be the case within medicine. This model of working time is currently being exacerbated by staff shortages, public spending budgets and the state’s encouragement of increased unsocial hours working for no additional payment, meaning it is difficult to change this pattern of work since the state is reliant on doctors working longer hours for less pay. For example, there is evidence from the findings of women returning from maternity leave and feeling guilty about leaving work at their scheduled leaving time. There is also evidence of male specialty trainees being denied LTFT training because they are expected to work to the full-time results based model.

Second, there appears to be an entrenched culture of excessively long working hours in medicine that is also difficult to reverse. Working hours in medicine remain excessive in comparison with other professions and occupations. For example, as discussed in the literature review, the average paid full-time working hours for accountants is 37.4 hours per week and for legal professionals 35 hours per week. Although it is found that legal and accountancy professionals work additional unpaid hours per week (TUC, 2017), working hours are still much lower than in medicine if unpaid additional work is factored into a standard full-time 48 hour week. However working hours in medicine are less compared to the working hours prior to the introduction of the EWTD. Most doctors currently working in consultant and GP Partnership roles will have trained during a time when there were no regulations on their working time. Therefore, the findings show they perceive specialty trainees’ current working time arrangements as much better than what they experienced. Tsouroufli et al (2011) looked at this and found that senior hospital doctors use their nostalgia for working excessively long hours as a mechanism to entrench high levels of professionalism and commitment within medicine. The consequence of this is the exclusion of female doctors who cannot meet the demands of “all hours training” (Tsouroufli et al, 2011). This research can confirm that the nostalgia among the more senior doctors interviewed does play a role in the working time of specialty trainees, with most consultants referring to working hours being much more excessive when they were in training. Many consultants commented on current specialty trainees
being people whom work to live, rather than live to work. However, there is not evidence in this research that consultants are purposefully not allowing working hours to be reshaped to reflect feminisation in the pursuit of entrenching the profession’s elite status. Instead, it appears that there are not the resources available to lower working hours.

This leads to the third point of the role of the state as the employer of doctors (and its other roles discussed earlier in this chapter) and patriarchy within the profession itself and institutions with influence over the employment relationship. Numerous authors highlight that organisations and professions are inherently gendered, based on the premise of patriarchy (Acker, 2006; Witz, 1992). There appears to be strongly-rooted patriarchal notions within the medical profession and the majority of the relating institutions. Although Acker’s (2006) inequality regimes framework applies to how organisations create inequality regimes, in the case of medicine it appears the state plays a major role in creating them as the production of inequality regimes caused by an understaffed and under-resourced service.

Fourthly, because the NHS is so complex and involves many state-led actors, responsibility may become fragmented and diffused. For example, the findings show that the detached nature of the HR department encourages specialty trainees to approach their TPDs and educational supervisors instead with employment related issues, whom often do not have the capacity or interest to resolve these issues. In addition the state as a whole, along with state-led institutions, plays a key role in determining working time policies and practices within medicine. As discussed in more detail in the context chapter, ‘the state-led actors’ within doctors’ employment comprises of the Department of Health, Health Education England and NHS local employers. Although these institutions operate somewhat separately, they are all governed by the overarching state and are consequently subject to financial constraints caused by public spending. Then there are the respective Royal Colleges for each medical specialty, which doctors at all stages of their careers are required to pay to be a member of. The Royal Colleges are separate to the state and determine the standards of their respective medical specialty, and are responsible for formulating
and assessing specialty-training programmes. The specialist trade union, the BMA, is also involved in the relationship as they are responsible for promoting doctors’ interests and negotiating with employers regarding terms and conditions. Within the working relationship, there are also senior doctors who may have responsibility for rota setting, managing specialty trainees, and directing training programmes for their region; all of whom are responsible for working time arrangements. This ultimately means that changes in attitudes and approaches to the extreme model of working time would most likely require a collaborative approach between all of the key actors within this employment relationship. This, together with the problem of a lack of resources, means nothing is done to specifically help female doctors and adapt the profession as a whole to feminisation. Perhaps it is the case that because there are numerous actors involved in the employment relationship of doctors, that responsibility for improving the employment experiences of doctors and responding to the effects of a feminising workforce has been diffused, thus explaining why enough has not been done.

**CONCLUSION**

This discussion has added to the debates surrounding the four key areas to arise from this research of: gender segregation, devaluation, working time, and the state as an employer.

The research shows that gender segregation is becoming further entrenched within the medical profession. This segregation is mainly due to ‘diversionary pathways’ (rather than ‘defence mechanisms’ coined by Bolton and Muzio (2008)) encouraged by the state and Royal Colleges through their organisation of training programmes and availability, and accommodation, of LTFT training of medical specialties. Therefore this research provides an alternative framework to that of Elston (2009), and uses the findings to develop a new framework to explain the key drivers for feminised and feminising medical specialties.

This research also provides some support for the theory of devaluation (England, 1992; Reskin and Roos, 1990; Crompton and Sanderson, 1990). However, it is likely that the
full impact is yet to be seen, as feminisation is relatively recent within the qualified medical workforce. The discussion also builds on Hyman’s (2008) work by noting the importance of the state’s role of delivering a ‘good’ public service, and considering the impact the role of the state has when looking at feminising professions, particularly those within the public sector. This research disagrees with some of Crompton and Lyonette’s (2010) findings surrounding the medical profession, mainly because of their focus on general practice. It can be seen from this research that numerous medical specialties should be analysed when looking at such a complex context.

This research supports the work of Rubery et al (2005a) and Fleetwood (2007), that working time trends, and respective remuneration for hours worked, within medicine are increasingly shifting towards that seen in most service sector occupations, despite medicine being an elite profession. In addition, this research also highlights that part-time work (referred to as LTFT) in medicine does led to doctors experiencing negative impacts despite the profession having an elite status and requiring numerous years of intense academic training. Thus the problems associated with part-time work for careers are not confined to typical part-time jobs seen as requiring low skill or commitment. Although LTFT work in medicine is relatively well paid compared to most part-time work (Crompton and Lyonette, 2010), it does not take away the differences in employment experiences seen between part-time and full-time doctors, similar to other occupations.

This discussion chapter also shows that the adjacent areas of gender segregation, devaluation, working time and the state interlink to create the phenomena shown in the findings that illustrates how the medical profession is being shaped by recent feminisation. This research argues that these linking areas create a context within which gender inequality and attributes of devaluation can thrive, which is largely driven by state’s numerous roles as: the employer, the deliverer of a public service and monitor of costs as the state appears to be the main stimulus of issues surrounding extreme working hours that causes most of the consequent evidence of devaluation and gendered negative impacts towards women.
CHAPTER NINE

CONCLUSION

INTRODUCTION

The primary aim for this research was to understand the implications of, and responses to, the feminisation of the medical profession in England, through exploring the changes in the employment and careers of doctors and their relationship, if any, to the feminisation of the medical profession. Key areas of relevant literature were identified and thoroughly reviewed to establish a framework that helped in formulating the four main research questions in relation to the impacts of feminisation on segregation, devaluation of the profession, organisation of working time and the impact of the state. The context for the changes was identified and an appropriate methodology selected to explore these research questions.

The findings were presented in relation to three key stages of the medical career trajectory – specialty choices, employment as a specialty trainee, and employment in ‘destination jobs’ i.e. consultants and GPs. The main empirical and theoretical contributions of this research are summarised below, followed by a discussion of the research limitations and potential avenues for future research.

RESEARCH CONTRIBUTIONS

Firstly, the research contributes to literature on gender segregation, and specifically gender segregation in the medical profession. The term ‘diversionary pathways’ has been coined to explain the interventions (and lack of) by the state and, to a lesser extent, the Royal Colleges lead women to medical specialties that are perceived as being more conducive to family life. This research has also led to the theoretical development of a new framework to explain why women are more attracted to certain medical specialties, and thus why the gender segregation across medical specialties is becoming further entrenched. The researcher believes this framework could be used as a tool to identify medical specialties that require more availability, and
accommodation, of LTFT training if they are to attract and retain specialty trainees (most of whom are women, who are more likely to seek LTFT training).

Secondly, the research has contributed to debates surrounding the theory of devaluation and provides evidence that suggests potential devaluation of the medical profession’s ‘elite’ status. Although feminisation of the medical profession is too recent for this research to see the full extent of any devaluation, the interventions of the state appear to be the main driver for potential devaluation, for example through the changes to the junior doctors’ contract. However, similarly to when the NHS was formed, doctors appear to still have bargaining power. Thirdly, the research shows that working time is an integral part of the phenomenon currently seen within the medical profession. Again, it appears to be the roles of the state that has exacerbated the extreme model of working time by creating a hybrid model of results-based and standard working time, which in turn has shaped gender segregation and devaluation of the profession.

Fourthly, this research contributes towards Hyman’s (2008) list of roles of the state to highlight the importance of the state’s role as ‘the deliverer of a public service’ under its role of shaping the welfare state. The highly politicised nature of the NHS as a public service appears to be a key driver in the state’s actions towards the employment conditions of doctors. Moreover, there is evidence that the state frames its use of new public management, for example claiming changes to the junior doctors’ was to improve patient care by achieving a truly ‘seven day NHS’ could be said to be a pseudo market pressure to lower pay and normalise unsocial hours working.

Lastly, the findings show that a range of actors, including the doctors themselves, have shaped the employment experiences of doctors during a period of feminisation, highlighting the importance of considering the roles of the state and other institutions with influence over the employment relationship when conducting research concerning the feminisation of professions, particularly in the public sector. The different sets of actors involved in this research appear to have differing motives in their actions, and lack of action, that affect the employment experiences of doctors. The BMA and Royal Colleges appear to have a vested interest in maintaining the elite
status of medicine and ensuring good employment terms and conditions for doctors, so they have played a key role in stopping the full extent of how the state has tried to shape the employment of doctors, for example their support for mitigating junior doctors’ contract changes, and the state’s proposed scrapping of CEAs. However the various roles of the state, that underpin the research findings, largely appear to negatively impact the employment experiences of doctors due to their main aim of cutting costs during a time of economic austerity. The interventions, and lack of intervention, of the state through the arrangements that shape working time, medical specialty choices, career progression, and pay has further entrenched gender segregation, led towards the potential devaluation of the medical profession, and exacerbated excessive working hours. The actions of the state are also adjusting the social contract of doctors by shifting powers away from medical professionals, for example through undermining their self-regulation of what constitutes as safe working time and introducing the requirement for consultants and qualified GPs to provide evidence to for annual revalidation to maintain the ability to practise medicine in the UK, which in turn lowers the professional status of the medical profession. This research also provides support for the argument of the state’s conflicting role of ‘model employer’, including its public sector equality duty; and maintaining costs (Hyman, 2008; Coffey and Thornley, 2009; Conley, 2012). Thus leading to the degradation of female-dominated professions, as seen similarly in the teaching profession (Conley and Jenkins, 2011). Overall the research appears to suggest that both an extreme model of working time and the involvement of the state as the employer, alongside its other roles, means devaluation of a feminising profession is more likely.

EMPLOYMENT POLICY AND PRACTICE CONTRIBUTIONS
Potential policy contributions arise in the areas of medical specialty recruitment, workforce planning, employment retention and contributors to the gender pay gap found in the medical profession.

Recruitment
The research shows that the organisation of specialty training programmes plays a key role in shaping the gendered decision making of specialty trainees, such as the geographic stability, run-through and training length. In addition, many women are deterred from entering GP Partnership roles due to high workloads, extreme working hours and precarious GP Partnership agreements. As more women continue to enter the medical profession, it is likely that gender segregation will become further entrenched, and may lead to certain medical specialties that do not have training programmes conducive to having childcare responsibilities to become under-filled in the future, such as A&E and surgery. The continuing fall in qualified GPs taking up GP Partnership roles also appears to be an issue that could cause detrimental consequences to general practice, as it is a system that relies upon qualified GPs to take up these roles to operate. The state, and other institutions involved in the medical employment relationship, should consider gender mainstreaming when organising training programmes and formulating employment practices, and policies. Practical steps to attract more women into GP Partnership roles could include putting in more legally robust sanctions within Partnership Agreements in terms of maternity leave and pay; and reducing workload pressures of GP practices.

**Workforce planning**

Implications of this research show that the current organisation of training encourages women to plan a family, and thus take time out of employment, towards the end of their training programmes. In addition, the number of training numbers allocated at the beginning of a training programme could better reflect the likelihood of specialty trainees taking time out of programme for maternity leave and/or working LTFT. This is particularly problematic in paediatrics as it is a long training programme carried out full-time, regardless of factoring in additional training years through maternity leave and LTFT working. In addition, as paediatrics is a run-through training programme, female trainees may take time out of training to start a family earlier in training as they have the security of a training post to return to.

**Retention**
The excessively long working hours, seen particularly at specialty trainee and qualified GP levels, are likely to contribute to doctors experiencing burnout, which impacts on the retention within medical specialties and the medical profession as a whole. Therefore it is likely that more doctors, both male and female, will have little option but to work “part-time” (although these hours are more inline with the UK standard average full time hours), and/or retiring from the profession earlier, leaving the profession entirely, or work overseas where employment conditions are perceived as superior to those found in the NHS.

**Gender pay gap**

CEAs are shown to be a key contributor towards the gender pay gap found in medicine. The self-application process and the criteria for awards deter women from applying, as receiving an award is largely determined by the ability to work long hours above already excessively long standard working hours. The imposed junior doctors’ contract may also deter women from entering research posts during their training programmes, which is likely to have an effect on the number of women in academic medicine posts and ultimately impacting on female consultants’ abilities in the future to apply for CEAs as contribution to research is a criterion for awards, particularly the highest national level amounts.

**LIMITATIONS OF RESEARCH**

One of the main limitations of this research was that the sample did not allow for intersectional analysis of the data as initially planned, as most of the participants identified as White British. In addition, all but one specialty trainee interviewed gained their medical degree in the UK. Again, it was difficult to thoroughly explore the impact being an IMG may have on employment as a doctor even though the broader survey data does suggest that being an IMG shapes medical specialty choices, particularly male IMGs opting for general practice. Another limitation was the difficulty in accessing a larger number of consultants and GPs to interview. As highlighted in this research, doctors’ excessive working hours and the sheer level of work they are required to complete meant qualified GPs especially were difficult to recruit to participate in the research. Interestingly, the researcher also learnt informally through
conversations with participants that the term “feminisation” in the research title deterred certain individuals from taking part as they viewed the term negatively. In some ways, this is a finding in itself, that individuals within the profession see ‘feminisation’ as contentious phrase. The unanticipated coincidence of the timing of the research with the junior doctors’ strike could also be seen as a limitation as responses were shaped by the talks of proposed changes to specialty trainees’ contracts even though it was not the core focus of this research as the dispute was not anticipated when the research was planned.

DIRECTIONS FOR FUTURE RESEARCH
This research could pave the way for future research looking at other recently feminising professions in the public sector, such as policing, and also recently feminising professions in the private sector, such as architecture and veterinary medicine. A comparison of private and public sector feminising professions would establish how much the state’s roles have an impact on employment conditions, and their impact on women, as well as devaluation. Another example of future comparative research could be comparing medicine with other long-established female-dominated public sector professions with additional work outside of working hours, such as teaching and nursing.

Other medical specialties, namely emergency medicine; cardiology; dermatology; and psychiatry could also be explored to provide a fuller picture of the factors shaping segregation: emergency medicine due to the excessive working hours and the dominance of men within the specialty; cardiology because it is male-dominated; dermatology because of the structured working hours and fewer weekend working hours, and psychiatry because of the high number of IMGs working within the specialty. The results of this research may also be different in the contexts of NHS Scotland and NHS Wales, as they have not experienced changes to the junior doctors’ contract. Longitudinal research of doctors currently working within the early stages of specialty training over a ten-year period would also be enlightening to see effects of junior doctors’ contract.
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APPENDICES

Appendix 1: Interview Schedule for Specialty Trainee interviews

Career choices

What attracted you to a career in medicine?

Prompt: Have you had any exposure to medicine to make you choose it as a career? For example: family, friends or personal experiences.

Why did you choose [specialty choice]?

Dependent on questionnaire response – The survey you completed states that [specialty choice] was your first choice, what factors made you choose your current specialism instead?

Dependent on questionnaire response – what made you decide to undertake your specialty training in the UK?

Do you feel the training structure for your specialty has had an impact on your decision to choose this particular specialty?

Do you feel the pay structure for your specialty has had an impact on your decision to choose this particular specialty?

Do you feel certain specialties are perceived to be ‘better’ than others?

Prompts: if so which ones? Why do you think this is?
Do you feel certain specialties are perceived better in terms of salary?
Do you feel certain specialties are perceived better in terms of status (i.e. difficulty of entry and qualifications)?
Do you feel certain specialties are perceived better in terms of employment experience (i.e. work-life-balance)?

Are you satisfied with your specialty choice?

Prompts: if yes, why? If no, why?

Please tell me about your experiences of the recruitment process for your specialty.

What are your views of the e-portfolio that you had to develop for your application for specialty training?

Prompts: do you update it regularly? Do you think the points system used for selection is fair?

Career progression

What are your career goals for the next 5 years?
Do you do any work-related activities outside of your scheduled working hours? For example: attending conferences, reading up on new developments or writing papers.  
**Prompt:** do you feel these help with your career progression?  
How much time do you spend on each?

Are there any non-work related activities that you undertake that you feel may help with your career progression?  
**Prompt:** for example, are there any activities which you would include in your e-portfolio and / or which have been mentioned during a selection process?

What barriers, if any, do you feel may hinder your career progression?

Do you feel there will be enough consultant posts available for when you complete your training?

What are your expectations after you complete your training programme?

**Work life balance issues**

How many people live in your household?  
**Prompts:** if mention of a partner, are they also a doctor? What is their job?

*If partner is a doctor* – what specialty are they training towards? Have you had to consider their career choices when making your own? Has both of you being doctors had an effect on your work-life-balance?

Do you have any children?  
**Prompts:** if yes, how old and how many?  
What effect has this had on balancing your work and family life?  
**Prompts:** if no, do you feel your career in medicine will have an effect on if or when you decide to have children?

Are you currently working full or part time?

According to the rota how many scheduled hours do you work, on average, each week?

What are the most hours you have worked in a week?  
**Prompt:** How often does this happen?

Do you feel that your shift rotas are designed fairly?  
**Prompts:** who is responsible for your rota?  
Do you feel certain individuals are treated more favourably than others when the rota is designed?
Do your working hours have an effect on your ability to balance your work-life and home-life?  
**Prompt:** if so, how?

How important was work-life-balance to you when you chose your specialty?

Do your working hours make you reconsider your specialty choice?

**Work content / culture / team-working**

How would you describe the culture of your specialty?  
**Prompts:** do you feel the culture is different to other specialties? If so, how?  
Did the culture of your specialty influence your decision to choose it to specialise in?  
Is the culture of your specialty different to what you expected? If so, how?

Who do you work alongside with on a day-to-day basis?  
**Prompts:** what is your working relationship like with these people? (i.e. senior doctors, peers, managers, admin, nurses).

Do you feel that your gender has had or will have an impact on your:  
Work content?  
Team-working?  
Specialty’s culture?

Do you feel that your ethnicity has had or will have an impact on your:  
Work content?  
Team-working?  
Specialty’s culture?

**Feminisation**

Over the last ten years there has been an increase in women entering the medical profession, with women now outnumbering men at medical school. Do you feel this has had an effect on the medical profession?  
**Prompts:** if so, how?  
Do you feel the increase in women entering the medical profession has had any personal effect on your career and work experiences?

Royal College of Physicians president Jane Dacre said that while females are better represented in medicine than ever before, the leaders are still largely ‘pale, male and stale’. What do you think Jane Dacre means by this?  
**Prompt:** What are your views on this statement?
One researcher (Riska, 2001) claims that feminisation of the medical profession may lead to the “humanisation” of the profession. What do you think Riska means by this?

**Prompt:** How much do you agree with this statement?

There have been numerous articles in the media claiming that women doctors are weakening the medical profession. What are your views on these statements?

Do you feel women doctors are well supported when they return to work after having a baby?

**Prompts:** if not, have you experienced evidence of this? If yes, what measures are put in place to support them? Who is responsible for supporting them?

**Human Resources**

If you have a work related problem, or issue, who would you raise this with?

**Prompts:** how would you raise your issue (for example, in person, via email or over the telephone?)

Do you liaise with those responsible for Human Resources at the Deanery?

**Prompts:** if yes, how often? What type of issues do you raise? If no, why? How would you contact them? For example: in person, via email or over the telephone?

Do you liaise with the Human Resources department at the Trust Level?

**Prompts:** if yes, what is your experience of the HR department? If no, why? Is the HR department approachable?

Are HR policies easily accessible to you?

**Prompt:** how do you access HR policies?

What are the issues you approach HR about most often?

To what extent do HR policies reflect your working needs?

**Collective bodies**

Are you a member of a trade union?

**Prompt:** which one?

How long have you been a member for?

What made you decide to become a member of a trade union?

Are you involved in any of the communities within the trade union?
Do you play an active role within the trade union?  
**Prompts:** do you attend any meetings? Write articles?

Do you feel your union has a positive impact on issues that directly affect you?  
**Prompt:** if no, what sort of issues are they dealing with?

**Close**

Is there anything you would like to add?

Do you have any questions for me at this point?

Thank you for your time, please feel free to contact me if you would like to elaborate on any of your answers or ask me any questions.
Appendix 2: Interview Schedule for Consultant/GP Partner interviews

Career choices

What attracted you to a career in medicine?

Prompt: Have you had any exposure to medicine to make you choose it as a career? For example: family, friends or personal experiences.

Why did you choose [specialty choice]?

Prompt: have you always worked in this specialty? Was it your first choice?

How long have you been a consultant/GP?

Prompts: Tell me about the recruitment process when you reached consultant level? Did you experience any difficulties when applying for consultant posts?

Do you feel the training structure for your specialty had an impact on your decision to choose this particular specialty?

Do you feel the pay structure for your specialty had an impact on your decision to choose this particular specialty?

Do you feel certain specialties are perceived to be ‘better’ than others?

Prompts: if so which ones? Why do you think this is?
Do you feel certain specialties are perceived better in terms of salary?
Do you feel certain specialties are perceived better in terms of status?
Do you feel certain specialties are perceived better in terms of employment experience (i.e. work-life-balance)?

Are you satisfied with your specialty choice?

Work life balance issues

How many people live in your household?

Prompts: if mention of a partner, are they also a doctor?

If partner is a doctor – what specialty are they training towards? Have you had to consider their career choices when making your own? Has both of you being doctors had an effect on your work-life-balance?

Do you have any children?

Prompts: What effect has this had on balancing your work and family life?
Prompts: if no, do you feel your career in medicine will have an effect on if or when you decide to have children?

Are you currently working full or part time?

According to the rota how many scheduled hours do you work, on average, each week?
What are the most hours you have worked in a week?

**Prompt:** How often does this happen?

Do your working hours have an effect on your ability to balance your work-life and home-life?

**Prompt:** if so, how?

How important was work-life-balance to you when you chose your specialty?

Do your working hours make you reconsider your specialty choice?

Do you feel that your shift rotas are designed fairly?

**Prompts:**
- who is responsible for your rota?
- Do you feel certain individuals are treated more preferably than others when the rota is designed?

**Work content / culture / team-working**

How would you describe the culture of your specialty?

**Prompts:**
- do you feel the culture is different to other specialties? If so, how?
- Did the culture of your specialty influence your decision to choose it to specialise in?
- Is the culture of your specialty different to what you expected? If so, how?
- Do you feel as though the culture has changed since you started your career?

Who do you work alongside with on a day-to-day basis?

**Prompts:**
- what is your working relationship like with these people? (i.e. junior doctors, peers, managers, admin, nurses).

Do you feel that your gender has had or will have an impact on your:

- Work content?
- Team-working?
- Specialty’s culture?

Do you feel that your ethnicity has had or will have an impact on your:

- Work content?
- Team-working?
- Specialty’s culture?

Have you noticed a change in the demographics of specialist trainees?

**Prompts:**
- what are the changes? Do you feel as though this has effected the medical profession?

What are your views regarding part-time junior doctors?

What are your views regarding part-time consultants?
Do you think current specialist trainees have a different experience of medicine than you did?

**Prompts:** if so, how?

What are your expectations for the future of your specialty?

**Feminisation**

Over the last ten years there has been an increase in women entering the medical profession, with women now outnumbering men at medical school. Do you feel this has had an effect on the medical profession?

**Prompts:** if so, how?

Do you feel the increase in women entering the medical profession has had any personal effect on your career and work experiences?

Royal College of Physicians president Jane Dacre said that while females are better represented in medicine than ever before, the leaders are still largely ‘pale, male and stale’. What do you think Jane Dacre means by this?

**Prompt:** What are your views on this statement?

One researcher (Riska, 2001) claims that feminisation of the medical profession may lead to the “humanisation” of the profession. What do you think Riska means by this?

**Prompt:** How much do you agree with this statement?

There have been numerous articles in the media claiming that women doctors are weakening the medical profession. What are your views on these statements?

Do you feel women doctors are well supported when they return to work after having a baby?

**Prompts:** if not, have you experienced evidence of this?

If yes, what measures are put in place to support them?

Who is responsible for supporting them?

The Edgware and Hendon Division of the BMA felt that the current process of allocation of Clinical Excellence Awards (CEA) appears to disadvantage women and BME doctors. Do you think the process unfair?

**Prompts:** if yes, why? How could it be changed? Have you applied for a CEA?

**Human Resources**

What role do you have in shaping employment practices?

**Prompts:** what is your involvement in the selection of trainees at regional level? What is your involvement in staffing rotas?

Who is responsible for the formulation of employment practices?

**Prompts:** is it a combination of consultants and HR?
If you personally have a work related problem, or issue, who would you raise this with?  
**Prompts:** how would you raise your issue (for example, in person, via email or over the telephone?)

What are the issues you approach HR about most often?

Are HR policies easily accessible to you?  
**Prompt:** how do you access HR policies?

To what extent do HR policies reflect your working needs?

**Collective bodies**

Are you a member of a trade union?  
**Prompt:** which one?

How long have you been a member for?

What made you decide to become a member of a trade union?

Are you involved in any of the communities within the trade union?

Do you play an active role within the trade union?  
**Prompts:** do you attend any meetings? Write articles?

Do you feel your union has a positive impact on issues that directly affect you?  
**Prompts:** if no, what sort of issues are they dealing with? If yes, how?

With the increased number of women in medicine, have you noticed a change in the issues the union are addressing?

**Close**

Is there anything you would like to add?

Do you have any questions for me at this point?

Thank you for your time, please feel free to contact me if you would like to elaborate on any of your answers or ask me any questions
Appendix 3: Interview Schedule for BMA Representative interviews

What are the current demographics of your members?

Does the union put into practice any strategies to attract certain member demographics?
   Prompts: if yes, please explain. Has this helped increase the number of members?

Feminisation

With the increased number of women entering the medical profession, have you noticed any changes in the issues the union addresses?

Has the feminisation of the medical profession affected the union?
   Prompt: If so, how?

Over the last 10 years there has been an increase of women entering the medical profession, with women now outnumbering men at medical school. Do you feel this has had an effect on the medical profession?

There have been numerous articles in the media claiming that women doctors are weakening the medical profession. What are your views on these statements?

In terms of the employment related issues the union has resolved, have you noticed any changes in the employment issues raised since the increased number of women in the profession?

Have you experienced any evidence of pay downgrades associated with the increased number of female doctors?

Is the lack of consultant posts for qualified CCT holders an issue you are actively addressing?
   Prompts: if no, why not? If yes, how would you address this?

At the latest BMA Annual Representative Meeting, it was highlighted that there is a need for more female doctor role models. Do you agree with this statement?
   Prompt: if so, what measures do you think should be put in place to achieve this?

Also, at the latest BMA Annual Representative Meeting, it was felt that women are under-represented in medical politics. Do you agree with this statement?
   Prompt: if yes, why do you think this is?

The Edgware and Hendon Division of the BMA felt that the current process of allocation of Clinical Excellence Awards (CEA) appears to disadvantage women and BME doctors. Do you think the process unfair?
**Prompts:** if yes, why? How could it be changed?

**JD Contract**

What do you think the impact of the new junior doctors’ contract will be?

Do you feel the proposed ‘7 day NHS’ is feasible with the resources available?

Do you think more doctors will have to opt to work part-time as a result of this?

One of the agreed terms of the new contract is the option of ‘accelerated training’ – how realistic do you think it is that this suggestion can be implemented effectively?

Do you feel Jeremy Hunt’s approach to the junior doctors’ contract reflects the feminisation of the profession?

What effect do you think the proposed changes to consultant contracts will have on the medical profession?
Appendix 4: Interview Schedule for Royal College Officials

What made you decide to become an official of your Royal College?

How long have you been in this role?

What are the demographics of your members?

Does the college put into practice any strategies to attract certain member demographics?

Prompts: if yes, please explain.

What are the most common issues you deal with?

Have the issues your College addresses changed due to the increased number in women doctors?

To Royal College of General Practitioners:

Why do you think there is a recruitment crisis for your specialty?
Why do you think more women are entering your specialty?
Do you feel the shorter training length for General Practice attracts more female trainees?

To Royal College of Anaesthetists:

Why do you think Anaesthetics is a specialty dominated by men?
Is the College trying to attract more female anaesthetists?
Has the increased number in women doctors affected your specialty?
3 out of 24 members of your College’s council are female. Why do you think this is? Do you think this will change in the future?

To Royal College of Paediatrics and Child Health:

Why do you think Paediatrics is a specialty dominated by women?
How has the increased number in women doctors affected your specialty?
Even though paediatrics is a female dominated specialty, men hold the majority of consultant posts. Is this an issue the college is addressing? Do you think there are enough female role models for specialist trainees?
Your college found that one in ten trainee paediatricians drop out of specialty training by year 3 of training – why do you think this is? What has the college done to lower this number?

What are your expectations for the future of your specialty?

Feminisation

With the increased number of women entering the medical profession, have you noticed any changes in the issues the union addresses?
Over the last 10 years there has been an increase of women entering the medical profession, with women now outnumbering men at medical school. Do you feel this has had an effect on the medical profession?

Royal College of Physicians president Jane Dacre said that while females are better represented in medicine than ever before, the leaders are still largely ‘pale, male and stale’. What do you think Jane Dacre means by this?

**Prompt:** What are your views on this comment?

One researcher (Riska, 2001) claims that feminisation of the medical profession may lead to the “humanisation” of the profession. What do you think Riska means by this?

**Prompt:** How much do you agree with this statement?

There have been numerous articles in the media claiming that women doctors are weakening the medical profession. What are your views on these statements?

**Close**

Is there anything you would like to add?

Do you have any questions for me at this point?

Thank you for your time, please feel free to contact me if you would like to elaborate on any of your answers or ask me any questions.
Appendix 5: Interview Schedule for TPDs

**General**

Over the last ten years there has been an increase in women entering the medical profession, with women now outnumbering men at medical school. Do you feel this has had an effect on the medical profession?

Has the increased number in women doctors affected your specialty?

With the increased number of women in medicine, have you noticed a change in the issues raised by trainees?

What are the main challenges for your specialty in terms of workforce planning?

How are rotations decided?

Is it difficult to accommodate those with childcare responsibilities so they are geographically closer to their homes?

How much notice do trainees receive with regards to where their next placement is?

Do you feel that LTFT training is becoming more common?

If yes, why?

Do you feel male doctors are just as likely to opt to work LTFT as female doctors?

Do you feel HENW puts in place initiatives to improve trainees’ work life balance?

- work outside scheduled working hours – how much is expected?

Do you think current specialist trainees have a different experience of medicine than you did?

**Prompts:** if so, how?

Do you feel female trainees are well supported at work whilst they are pregnant and when they return to work after having a baby?

**Prompts:** if not, have you experienced evidence of this?

If yes, what measures are put in place to support them?

Do you feel all cases are treated the same across the region?

The Edgware and Hendon Division of the BMA felt that the current process of allocation of Clinical Excellence Awards (CEA) appears to disadvantage women and BME doctors. Do you think the process unfair?

**Prompts:** if yes, why? How could it be changed?

Do you feel the number of female consultants/GP Partners is increasing in your specialty?

One researcher (Riska, 2001) claims that feminisation of the medical profession may lead to the “humanisation” of the profession. What do you think Riska means by this statement?
Prompts: What are your views on this statement? Do you feel work-life-balance issues are at the forefront of doctors’ personal agendas?

What are your expectations for the future of your specialty?

**JD Contract**

What do you think the impact of the new junior doctors’ contract will be on your specialty?

Do you feel the new contract will impact on trainees choosing to take time out to conduct research in your specialty?

Do you feel the proposed ’7 day NHS’ is feasible with the resources available to you?
- Do you think more doctors will have to opt to work part-time as a result of this?

One of the agreed terms of the new contract is the option of ‘accelerated training’ – how realistic do you think it is that this suggestion can be implemented effectively in your specialty?

Do you feel Jeremy Hunt’s approach to the junior doctors’ contract reflects the feminisation of the profession?

What effect do you think the proposed changes to consultant contracts will have on the medical profession?

**Paediatrics**

Why do you think Paediatrics is a specialty dominated by women?

It has been reported that there is a high drop-out rate in your specialty.
Why do you think this is the case?
How is HENW trying to reduce this number?

**Anaesthetics**

Why do you think female trainees are choosing anaesthetics at a greater rate compared to other specialties?

Has Anaesthetics as a specialty done anything to attract more female doctors?

**General Practice**

Why do you think there is a recruitment crisis for your specialty?

Why do you think more women are entering your specialty?
Do you feel the shorter training length for General Practice attracts more female trainees?
Appendix 6: Specialty Trainee Questionnaire

Question 1: What is your gender?

Female ☐

Male

Other, please specify …………………………………………………………………………………………………………………

Question 2: Please describe your ethnic group.

………………………………………………………………………………………………………………………………

Question 3: Where did you complete your primary medical degree?

UK ☐

Europe ☐

Outside of Europe ☐

Question 4: What specialty are you training towards?

Anaesthetics ☐

General Practice ☐

Paediatrics ☐

Question 5: What year of your training are you currently in?

……………………………………………………………………………………………………………………………………


Question 6: Please state the factors that were most important to you when you chose your specialty.

High amount of patient contact ☐
Low amount of patient contact ☐
Hospital setting ☐
GP surgery / clinic setting ☐
Flexible working hours / work life balance ☐
Shorter training length ☐
Availability of Less Than Full-time Training (LTFT) ☐
Salary ☐
Likelihood of gaining a place on the training programme ☐
Speciality culture ☐
Potential colleagues ☐

Please feel free to elaborate on your answer below:

........................................................................................................................................
........................................................................................................................................

Question 7: Is the specialty you are currently training in your first choice of specialty?

No ☐
Yes ☐
If ‘no’, please state your first choice below

........................................................................................................................................

Question 8: Do you feel your gender may have had an effect on your specialty choice?

No ☐
Yes ☐
If ‘yes’, please explain how below

........................................................................................................................................

Question 9: Do you feel your ethnicity may have had an effect on your specialty choice?

No ☐
Yes ☐
If ‘yes’, please explain how below

Question 10: Thank you for completing this survey. If you would be willing to take part in an interview with the researcher to discuss your career choices and working life, please state below:

Yes ☐
No ☐
### Appendix 7: Specialty trainee survey participants

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