Women in Hospital Medicine: Facts, Figures and Personal Experiences

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Abstract
Although females represent a high proportion of medical graduates, women are under represented at consultant level in many hospital specialties. Qualitative and quantitative analyses were undertaken which established female representation at all levels of the medical workforce in Ireland in 2011 and documented the personal experiences of a sample of female specialists. The proportions of female trainees at initial and higher specialist training levels are 765(53%) and 656(55%) respectively but falls to 1,685(32%) at hospital specialist level (p<0.0001). Significantly fewer women are found at specialist as compared to training levels in anaesthesia (p = 0.04), emergency medicine (p = 0.02), medicine (p < 0.0001), obstetrics/gynaecology (p = 0.0005), paediatrics (p = 0.006), pathology (p = 0.03) and surgery (p < 0.0001). The lowest proportion of female doctors at specialist level exists in the combined surgical specialties 88(10%); the highest is in psychiatry 380(53%). Qualitative findings indicate that females who complete specialist training are wary of pursuing either flexible training or part time work options and experience discrimination at a number of levels. They appear to be resilient to this and tolerate it. Balancing motherhood and work commitments is the biggest challenge faced by female doctors with children and causes some to change career pathways.

Introduction
Medicine was once a male-dominated profession reflecting the male preponderance in medical schools. Subsequently an increase in female undergraduate entry has led to an even gender balance or slight female dominance in medical schools. Decades later, the effects of this changing demographic at undergraduate level should be evident at senior clinical and academic levels. This has not happened, fuelling speculation about possible barriers and discrimination. An alternative explanation is that work practices could explain this disparity as women are more likely to have worked part time and this might influence career trajectory.

Results
In the mid 1990s the gender balance of NCHDs changed from a majority of males to females (Figure 1). Females represent the majority of medical school entrants in Ireland over the last few decades. Sixty percent of successful medical school applicants were female in 2008. This trend was transiently reversed in 2009 with a near 50:50 gender distribution and reverted to 60:40 in favour of females again in 2010. There is a corresponding predominance in the early stages of hospital specialist training, however women are a significant minority in hospital specialist professional competence schemes (Table 1 and Figure 2). Table 1 summarises gender distribution by specialty and level of training. Women occupied 15% of full academic medical chairs in the US in 2005 and account for 12% of UK medical professors. Evaluation of promotion trends suggests some workforce practices may be detrimental to women careers. There is a scarcity of relevant published data from Ireland. Our aim was to capture female representation at all levels of medicine and to establish, by interviewing women consultants, factors influencing career choice and progression.

Methods
Medical undergraduate data were obtained from the Central Applications Office and the Higher Education Authority. Gender distribution of non-consultant hospital doctors (NCHDs) were obtained from the Health Services Executive. Gender distribution of hospital consultants is not readily available from any source. The Medical Council provided information on numbers and gender distribution of doctors enrolled in the specialist divisions of professional competence schemes. Clinical academic staff data was sought individually through contact with each of the medical schools in the country. Chi-square tests were used to compare proportions of females in common hospital specialties at NCHD and specialist levels. Female hospital consultants affiliated with the Medical School in University College Cork were identified and a random sample across specialties and age groups were invited to participate. Semi-structured interviews were conducted by a single researcher. All interviews were recorded, transcribed, coded, assigned numbers to protect anonymity and analysed independently by 3 researchers. An inductive strategy through open and selective coding was used to derive the predominant themes.

Career choice and training
Qualitative data
Twenty-five of the 32 (78%) women invited agreed to participate. Participant demographics are outlined in Table 2. Six themes arose from the analysis of the interviews: career choice and training, support needed, discrimination, challenges at work, work life balance and changing practices in medicine.
The majority of interviewees 22/25 gave interest as their main and often only reason for choosing their specialty. Travel necessary to complete training was a focus in all interviews with 23/25 having trained outside of Ireland. This caused a particular strain on relationships and was felt to have caused colleagues to exit from hospital and academic life. The vast majority 24/25 advocated part-time training but none had pursued this option, as it was perceived to have adverse career implications.

Support needed
No one wanted special consideration because they were female and this line of questioning often drew a strong reaction. They had been employed on merit. Supports became critical when children arrived and the absence of these marked career decline. Five of the interviewees had husbands or partners who were either full-time house-husbands or who only occasionally worked and two had parents who had relocated to assist with childcare.

Discrimination
This was a particularly interesting aspect of all interviews. Four described overt discrimination at interview. They acknowledged that legislation probably prevented such incidents now and events described occurred a decade previously. Others noted that subtle questions are asked about your family plans at interview and had no issue with this. Twelve participants described appraisal experiences that were specifically discriminatory. There was evidence of discrimination from more junior male doctors and nurses. Almost one third of the participants had encountered bias from patients. For some was a tendency to become masculine so as not to invite discrimination. Others acknowledged having to work harder to compensate for being a woman.

Challenges succeeding at work
Motherhood was the common denominator to most of the difficulties encountered by participants. Issues included maternity leave, problems with travel and less time for research. All who had children noted that time out rapidly became the focus in interviews and consequently all had carefully limited this and ensured their CVs were full. Mothers and childless interviewees seemed equally aware of this phenomenon. Some had delayed starting a family until career security was attained. The view held by some senior consultants that part time work options are negotiable training plan at the outset or defined travel expectations and this would seem to be an issue that is addressed pragmatically. Motherhood is perceived as a career impediment and sadly evidence supports this. Until evidence emerges that part-time training will not be a disadvantage. Equally the time-out issue needs to be addressed pragmatically. Mothers and childless interviewees seemed equally aware of this phenomenon. Some had delayed starting a family until career security was attained. The majority 17/21 were dissatisfied and felt expectations were unrealistic and colleagues assumed they should just make the necessary commitments. Sacrifices were made by all mothers to deliver at work and their children were considered to have suffered. Older mothers expressed bitter regrets and three had dissuaded their daughters from pursuing a career in hospital medicine.

Changing practices in medicine
The majority (22/25) of interviewees saw more job sharing and part time work as the mechanism to retain women. Some noted that flexible work practices would benefit both genders in medicine.

Work-life balance
All of the childless and single women interviewed were satisfied with their work life balance although one noted the strains of juggling academic and clinical work. The majority of mothers 17/21 were dissatisfied and felt expectations of them were unrealistic and colleagues assumed they should just make the necessary commitments. Sacrifices were made by all mothers to deliver at work and their children were considered to have suffered. Older mothers expressed bitter regrets and three had dissuaded their daughters from pursuing a career in hospital medicine.

Discussion
This is the first study for decades to document women’s participation in hospital and academic clinical medicine in Ireland. We are the first to analyse qualitative data evaluating career choices, training obstacles and factors affecting progression of women in hospital clinical and academic medicine in Ireland. Our data suggest that the leaky pipeline in medicine persists and warrants ongoing monitoring and investigation. Policy makers and those with a responsibility for higher specialist training must evaluate and address the issues raised. This is especially pertinent at a time when the impacts of a potential manpower crisis and the NCHD exodus from hospital medicine are receiving such attention.

There are several limitations to the data presented. Protracted training paths and career progression in hospital and academic medicine means that the quantitative data represents events of a previous decade. Summary statistics suggest female are well represented at initial and higher specialist training level in many specialties. However, there appears to be a deficit at specialist level with a greater than 2:1 ratio of males to females. Some of this may be due to the age profile of specialists with a significant proportion having trained when there was a majority of males graduating. However, women have been in the majority at NCHD level for almost 2 decades and the degree of continuing discrepancy between males and females at more senior levels is surprising. In addition, women have not substantially ascended to professorial positions in academic medicine. Women are well represented at senior lecturer level and may be clustered here if we note the findings from research elsewhere.

Lifestyle does not appear to have influenced career choices at the outset but the uncertainty associated with travel and inflexibility in training and work especially when juggling motherhood leads to career changes. Few have had a negotiable training plan at the outset or defined travel expectations and this would seem to be an issue that is resolvable. There is little point in flexible training or working options if the prevailing perception is that pursuing these is equivalent to career suicide. The view held by some senior consultants that part time work options are evidence of lack of true commitment to the profession need to be addressed. This will influence training choices until evidence emerges that part-time training will not be a disadvantage. Equally the time-out issue needs to be addressed pragmatically. Motherhood is perceived as a career impediment and sadly evidence supports this.

Those who have attained their desired career end-point were resilient to discrimination from any quarter and may even tolerate it. Perhaps, in order to survive and progress, they have learnt to accept practices and behaviours which they may initially have rejected. Bearing in mind that our sample is comprised of women who have stayed in the profession,
References