

Women doctors: making a difference

Report of the Chair of the
National Working Group on Women in Medicine

Presented to Sir Liam Donaldson,
Chief Medical Officer

October 2009

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM & T Finance Social care/Partnership working
---	--

Document purpose	Policy
Gateway reference	12718
Title	Women doctors: making a difference
Author	Baroness Deech
Publication date	13 October 2009
Target audience	SHA CEs
Circulation list	Royal Colleges, Deaneries, PMETB, GMC, BMA, Equality and Human Rights Commission, ACCEA, Conference of Postgraduate Medical Deans
Description	In August 2008, the Chief Medical Officer asked Baroness Deech to chair an independent National Working Group to look at the position of women in the medical profession. Their report considers the current situation, reviews existing work and recommends a programme of action to improve opportunities for women in medicine.
Cross-reference	N/A
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	David Winks CMO Private Office Room 114, Richmond House 79 Whitehall London SW1A 2NS 020 7210 5853
For recipient's use	

Contents

Foreword	2
Open letter from the Chair of the National Working Group on Women in Medicine	4
Chapter 1: Executive summary of recommendations	7
Chapter 2: The current situation	11
Chapter 3: Barriers to success	23
Chapter 4: Recommendations and their rationale	36
Annex 1: Recommendations of previous reports	46
Annex 2: Terms of reference of the National Working Group on Women in Medicine	52
Annex 3: Chair of the National Working Group	53
Annex 4: Membership of the National Working Group	54
Annex 5: Evidence collected	66
Glossary	67
References	68

Foreword



Since 1997 there has been a radical expansion of the medical workforce in the United Kingdom. As outlined in the NHS Plan in 2000, this was initially achieved by welcoming qualified doctors from abroad to work within the NHS. However, it was always the intention that, in the longer term, domestic supply would be increased through an expansion in the number of places at medical schools within the UK. This expansion is now complete, and the number of places at medical schools has increased from 5,062 in 1997/98 to 8,148 in 2008/09.¹ The first tranche of this new generation of doctors has now entered the medical workforce as junior doctors.

The number of women entering medical school has increased significantly – from 492 (24.4% of the total admissions) in 1960/61 to 4,583 (56.2% of the total admissions) in 2008/09.² This is a remarkable achievement considering that women were actively prevented from becoming doctors a few decades ago. Despite this increase in women entering the profession over the last 20 years, few have reached senior leadership positions. The issues that have traditionally been associated with women in the workplace are going to become increasingly pronounced for the NHS, and it is of paramount importance that we address them now.

Many of the issues faced by the profession are equally pertinent to other healthcare workers. Indeed, they are not unique to medicine. However, unlike other professions, the constantly changing nature of practice – as well as the demands, both physical and emotional, of caring for patients – brings additional concerns for those responsible for ensuring a stable workforce. If we do not make provisions to ensure that the workforce is able to meet patient expectations and professional and academic requirements, then the UK will face a dramatic shortage of working doctors in the future. These doctors are likely to be lost to the profession when they are at a crucial stage in their careers – a stage when neither the patients they care for, nor the more junior doctors who rely on them for advice and support, can afford the loss.

In recent years, there has been considerable debate and discussion, and a number of studies have looked into the issues surrounding women in medicine. These studies have, in the main, focused on the barriers in particular specialties, such as surgery, or particular work areas, such as academia. I commissioned the National Working Group on Women in Medicine to review all these reports and to draw out the common threads in order to recommend a programme of action to improve opportunities for women in every field of medicine.

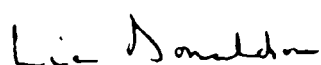
The issues raised are not new – nor perhaps are they unexpected. But to tackle them is going to require a step change in how the medical workforce as a whole behaves. It will require an acceptance of alternative and differing patterns of working and training for all medical staff, not just women. Wider changes in society, such as some men choosing to become the primary child carer, mean that the recommendations in this report are proposed not just to provide opportunity for women but to offer better options to the entire medical workforce. In my 2006 Annual Report I identified that 'the problem is not access to medical school but rather how we ensure that the female medical workforce is able to fulfil its potential once in employment'. It has become clear during the deliberations of this group that it is not just women who are affected by these issues. It is my hope, therefore, that this report will address the situation for both men and women doctors to create a more equitable pattern of work, recognition and reward.

I am grateful to have received the report and recommendations of the National Working Group on Women in Medicine from Baroness Deech, the group's Chair. I would like to thank Baroness Deech and her working group colleagues for the effort that they have put into a complex area, the enthusiasm with which they tackled the challenge and the hard work involved in producing such a comprehensive review.

The report contains a summary of the current situation facing doctors. The recommendations are focused, and the potential benefits are clear to see. Greater access to mentoring, recognition by the medical Royal Colleges that time alone does not indicate competence to practise independently, and improved feedback from the Clinical Excellence Awards scheme are all designed to help every doctor realise their potential. There are recommendations for additional support with childcare and for improvement in the opportunities for alternative working patterns. Each will require careful consideration as to how they can best help to achieve greater gender equity at the senior levels of the medical profession, and, more fundamentally, how they would ensure that good doctors are not lost to the NHS on account of problems that can and must be resolved.

I am very pleased to see that this report is a celebration of the successes to date of women in medicine. In recent years, important steps, such as the NHS Childcare Strategy, have been taken to address the demands in creating a workforce that meets clinician needs without compromising patient care and, indeed, expectations. This report is a blueprint for how these pioneering steps can be continued and their aims achieved.

It will take time to bring about the changes envisaged in the report. As a result, careful monitoring will be required to ensure that progress occurs and that the drive for implementation is maintained, despite the many competing priorities that continually challenge the NHS. It is for this reason that I am pleased to announce that I will hold an annual review meeting to assess the landscape for women in medicine. This meeting will provide an opportunity to review progress and ensure that additional efforts are made to guarantee continued success. Women fought long and hard for entry to medicine; it will require continuous commitment and effort to ensure that they fulfil their potential.



Sir Liam Donaldson
Chief Medical Officer, England

Open letter from the Chair of the National Working Group on Women in Medicine

Sir Liam Donaldson
Chief Medical Officer, England

Dear Sir Liam

In August 2008 you asked me to chair the National Working Group on Women in Medicine. I was pleased to accept your offer. This working group developed from the chapter in the 2006 Annual Report of the Chief Medical Officer, *Women in Medicine: Opportunity Blocks*. Just over 150 years ago, women had to fight to be allowed to enter medical schools. Today just over half of new medical graduates are female. We have had the advantage of reading the Royal College of Physicians' report of June 2009, *Women and Medicine: The Future*,³ which presents a high quality analysis of the relevant data and points out that the rising number of women doctors needs to be incorporated into the workforce in an effective and productive manner. Changes in working hours, career expectations and demand are issues that cannot be ignored. Many of the changes that women need in order to remain in medicine are equally sought by younger male doctors. These issues are not a problem unique to medicine; however, it is particularly problematic in medicine, because of patients' need for 24-hour care. A more user-oriented service is also rightly focusing on patient demand for continuity in some medical situations. This creates a challenge: more choice for doctors means less continuity of care for patients. Our aim is to make it more possible for women to work full time, whilst maximising the advantages of part-time work and training, when need be, along with parity of esteem for it.

You invited a formidable team of male and female doctors, from a variety of backgrounds, so as to cover the broad spectrum of issues that gender and medicine create. You asked the Women in Medicine working group to consider the current situation, review existing work and consult widely, and from this to create a programme of action to improve opportunities for women in medicine.

As the workforce in medicine changes, new challenges are arising – at medical student level there is a need to encourage a diversity of applicants. As the workforce becomes more female there is the risk of following other professions, where rising numbers of women have led to devaluation of the professional status and sometimes salary levels. The most recent research shows that, with the current level of influx of doctors from overseas, the gender balance in medicine in the UK is moving towards equity.

With an investment of nearly a quarter of a million pounds in every doctor, male and female, to take them through to full registration at the end of their Foundation 1 year, it is incumbent on the NHS to adapt to ensure that these precious resources are not lost but that they stay working for an organisation in which they feel valued and in which they can achieve their professional ambitions, providing good care for their

patients. No doctor should be wasted because they cannot find a place in the system that is compatible with their other roles as a parent and partner, and no doctor should be lost to medicine because of obstacles in the way of finding the right professional placement. We should make our goal a profession where every woman and every man goes as far as they wish and as far as their talents permit. The final judgement as to the success of the implementation of the recommendations of this report will lie in retention of doctors within the system, both men and women.

Our report traces the obstacles to the full exercise of every doctor's potential – from the decision at school to study medicine, through training, work, maternity leave, childcare, progress through the profession, possibly into positions of leadership and acknowledged excellence, to retirement and pensions – with special emphasis on the choices and problems that women face, though increasingly in today's world they are shared by men. Much of what we describe is not newly discovered. There have been several reports on the progress of women in medicine in recent years. We asked ourselves why the situation had not changed, why there was still discontent, and we have surmised that previous reports had focused on the desired outcomes rather than on the necessary levers of change to achieve them. So our report focuses very much on the implementation of change. The recommendations are narrow and targeted primarily in three areas:

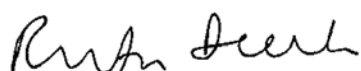
- The first is aimed at improving the existing structures so that there is better advancement to certain crucial career turning points as well as different ways of working.
- The second area is concerned with ensuring that new processes such as revalidation have the flexibility and capacity to accommodate doctors who may not be conforming to the usual working patterns.
- The final area is concerned with providing additional support for the practical realities of caring for a child or a dependent relative.

The list may seem short, but change will not happen overnight, and to maintain the momentum for successful implementation will require a commonly agreed set of goals that are achievable regardless of the shape of broader issues in the healthcare landscape that might be faced in the future. Where possible we have also tried to ensure that there is a single body accountable for the implementation of each recommendation so that there is a clear expectation of who will be responsible and accountable.

We have worked closely with colleagues within the Workforce Directorate of the Department of Health, the Department for Children, Schools and Families, and the Treasury. We have taken evidence from a wide range of people: academics, trainee and trained clinicians, regulators, patients and NHS managers. All stakeholders with whom we have engaged have shown understanding of the complexity of these issues, and commitment to addressing them. There is a clear recognition that, however difficult it is to focus on these concerns, they must be tackled.

I was impressed by the quality and dedication of the women doctors whom I was privileged to meet during the course of compiling this report. I saw how they made difficult choices in career and family situations, and I admired their commitment to medicine and their resilience. It was heartening to realise that some senior men in the medical profession appreciate this too.

I realise that the situation in the UK is not unique. Our extensive examination of the international experience has shown clear examples of best practice, but no single country has solved this issue to date. Given the illustrious history of women in medicine in the UK, it is fitting that the UK is seen to lead the way on this issue at a national level. I therefore commend to you this report of the Women in Medicine working group and its recommendations.



Baroness Deech
Chair, National Working Group on Women in Medicine

October 2009

I am deeply indebted to Dr Vivian Tang, Dr Claire Lemer and James Ewing for their work on this report.

Chapter 1:

Executive summary of recommendations

1.1 Recommendation 1: Improve access to mentoring and career advice

- 1.1.1 In the next round of contract negotiation there should be an explicit facility for appropriately trained and skilled doctors (usually consultants) to undertake mentoring or career counselling as a programmed activity within their job plan.
- 1.1.2 To facilitate accessing mentoring or career management support, the future commissioners of medical education should maintain a register of all doctors who are skilled and are willing to undertake these tasks and make it more accessible to other doctors.

1.2 Recommendation 2: Encouraging women in leadership

- 1.2.1 Appointments to NHS, academic and clinical committees and boards should be advertised widely and have a transparent and democratic process rather than simply an appointment by nomination.
- 1.2.2 Committees should be encouraged to develop their ways of working to enable greater participation by doctors who are parents or carers.
- 1.2.3 There should be increased access for women to the committees and boards of major medical institutions, including the medical schools, postgraduate deaneries, medical Royal Colleges, NHS trusts and other NHS bodies. The Equality and Human Rights Commission should consider auditing the appointments process for all such posts at these institutions, as they consider appropriate, to assess whether sufficient opportunity has been created to increase access for women to these respective organisations' committees and boards.

1.3 Recommendation 3: Improve access to part-time working and flexible training

- 1.3.1 The postgraduate deaneries should maintain a list of doctors wishing to train part time in a slot-share arrangement.
- 1.3.2 NHS Employers should develop guidance for meeting the costs of continuing professional development, including for those who are working less than full time.
- 1.3.3 The development of credentialling should be expedited, and there should be full recognition by the medical Royal Colleges that time alone does not indicate competence to practise independently.
- 1.3.4 The aspirational quota for part-time training should be abandoned in favour of a needs-assessed availability by strategic health authorities (SHAs). The newly formed Centre for Workforce Intelligence should be commissioned by each SHA to provide this needs assessment on a regional basis, and provision should be made to meet it.



Professor Stephanie Amiel
RD Lawrence Professor of
Diabetic Medicine, the first Chair
in this field

1.4 Recommendation 4: Ensure that the arrangements for revalidation are clear and explicit

- 1.4.1 The General Medical Council (GMC) and the appropriate medical Royal Colleges should ensure that they have a clear set of re-licensing and recertification standards and assessment processes in place for doctors who have taken time out of training or the profession to return to work.
- 1.4.2 Responsible officers should coordinate refresher training for those who have taken time out of training to meet these standards. There should be funding for this within the NHS budget.
- 1.4.3 Trusts should offer 'back-to-work' and 'taster' sessions where those who have taken a career break can shadow working doctors to re-familiarise the doctor with procedures and work patterns, so that they are confident on return.
- 1.4.4 The Postgraduate Medical Education and Training Board (PMETB) and the GMC should ensure that women in non-training grades receive support in applying for entry to the specialist register.

1.5 Recommendation 5: Women should be encouraged to apply for the Clinical Excellence Awards scheme

- 1.5.1 The Advisory Committee for Clinical Excellence Awards (ACCEA) should provide greater feedback to applicants and advice as to where additional development might be necessary.
- 1.5.2 ACCEA should develop a network of mentors who can be approached for advice. This should be coordinated with the wider career advice programme.
- 1.5.3 Selection panels should be gender balanced wherever possible; due consideration should be given to part time applicants, and ACCEA's processes should be monitored for gender equality.
- 1.5.4 The same encouragement should be applied to local awards, if any, and monitoring information from all trusts should be collected centrally for gender analysis.

1.6 Recommendation 6: Ensure that the medical workforce planning apparatus takes account of the increasing number of women in the medical profession

- 1.6.1 NHS Medical Education England (NHS MEE) and the Centre for Workforce Intelligence should ensure that workforce models for the future clearly delineate the effect of a rising number of women in the workforce so that appropriate advice for the workforce planning apparatus can be given.

- 1.6.2 For training, NHS MEE should commission the medical Royal Colleges to develop innovative solutions to these challenges. It is also noted that NHS MEE is conducting a review into the challenges that are presented by the European Working Time Directive, to improve the quality of training in reduced training opportunity circumstances, and this should address the particular issues for women.
- 1.6.3 The Centre for Workforce Intelligence should approach the GMC to discuss ways of tracking careers effectively through GMC numbers to allow accurate data to be collected to inform workforce modelling.

1.7 Recommendation 7: Improve access to childcare

- 1.7.1 The Conference of Postgraduate Medical Deans of the United Kingdom and the Department of Health should consider whether the model such as that in place in the North Western Deanery, which commissions a lead employer for all specialty trainees in the deanery, would be a practical and desirable model in the new education commissioner/provider landscape. The additional benefit of better facilitating access to government assistance for maternity benefits and childcare of this model is clear.
- 1.7.2 Postgraduate deaneries or their lead employers should plan ahead for the childcare needs of their trainees and facilitate arrangements between a trainee and the trusts during his or her rotation for access to childcare provision.
- 1.7.3 Trusts should appoint a childcare coordinator within their human resources department if they have not yet done so.
- 1.7.4 Childcare coordinators should develop internet resources to act as both an information resource and message boards on local childcare options, including emergency cover.
- 1.7.5 NHS trusts should engage with local authorities as key employers to ensure that local authorities fulfil their legal responsibility to ensure that the childcare needs of their population are met. NHS Employers should begin a programme of work to advise and coordinate NHS trusts to achieve this and help spread best practice.
- 1.7.6 NHS Employers should draw up guidance on good practice on what additional provision NHS trusts should make for childcare allowances for unavoidable unsocial hours of work.
- 1.7.7 Hospital-based childcare should move to extended opening hours. NHS Employers should host a conference of childcare coordinators with the objective of identifying how this and the specific needs of doctors can be achieved.



Dame Josephine Barnes
First female president of the
British Medical Association
and leading obstetrician and
gynaecologist

- 1.7.8** The Department of Health should explore the costs and benefits of doctors (and other healthworkers in similar circumstances) who are parents paying for full-time or part-time childcare as a value-for-money solution for enabling doctors to progress their careers. On the basis of this analysis the Department should submit a case to the Treasury to allow doctors to pay for childcare from their gross earnings. In addition, it should establish whether any central funding might be available for childcare assistance. The working group believes that this is fundamental to ensuring that all doctors can fulfil their potential.
- 1.7.9** The Centre for Workforce Intelligence should urgently model the effects of greater female participation in general practice and the potential costs of maternity cover. Contractual changes should be considered based on this modelling to compensate maternity leave should it be required.
- 1.8 Recommendation 8: Improve support for carers**
- 1.8.1** All postgraduate deaneries or their nominated lead employers and NHS trusts should have a lead person responsible for supporting carers.
- 1.8.2** The NHS should join Employers for Carers and benefit from the financial advantages conferred when adopting carer-friendly employment practices. Doctors who are family carers have particular difficulties with long, unpredictable and inflexible hours of work.
- 1.9 Recommendation 9: Strenuous efforts should be made to ensure that these recommendations are enacted through the identification of champions**
- 1.9.1** Trusts should identify a non-executive director to have responsibility at a local level for improving working patterns, giving advice and handling complaints. The director should work closely with a lead consultant for workforce planning.
- 1.9.2** Royal Colleges should follow the example of the Royal College of Psychiatrists and develop gender equality plans.

Chapter 2:

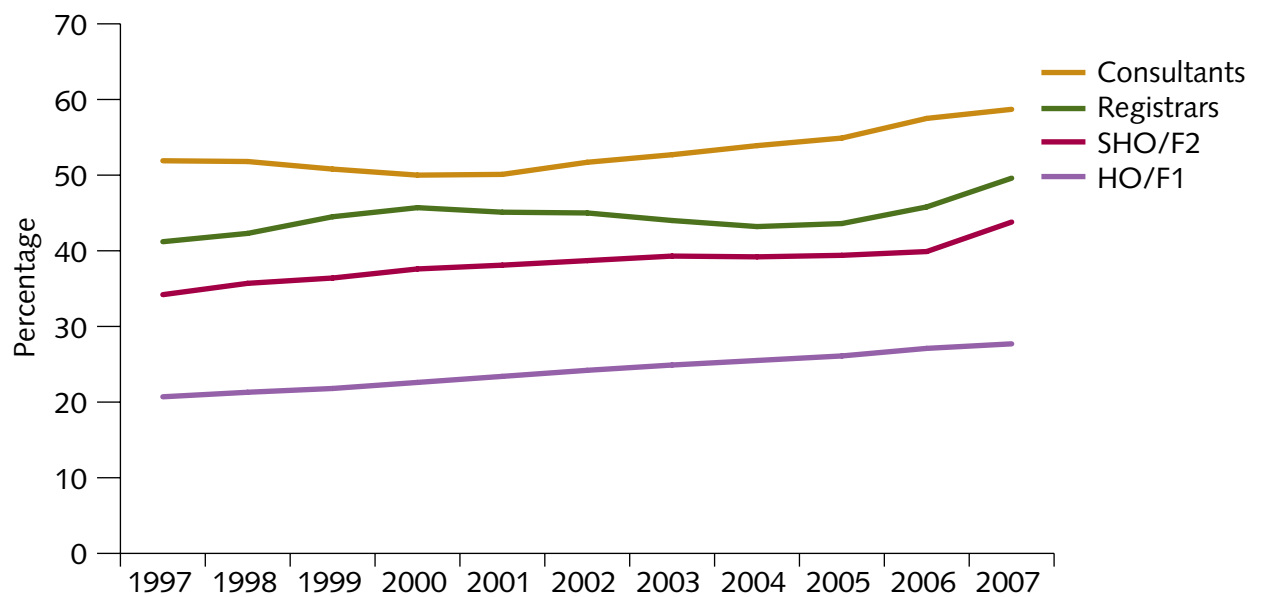
The current situation

- 2.1** Meeting the future with an increasingly female workforce presents us with a series of challenges; however, many of these are not unique to medicine. Lessons can be learnt from other professions that have undergone or are undergoing similar demographic shifts. Evidence from other professions that have seen similar demographic change, such as teaching or law, suggests that this workforce change may be accompanied by a decline in the esteem in which the profession is held and that it is often coupled with a reduction in remuneration, as evidenced by the existence of a gender pay gap. Research from the Law Society salary survey in 2007 shows that female salaried partners earned an average of £46,999, whereas their male colleagues earned £80,000.⁴ In addition, only 45% of women solicitors of 10 years' standing in private law practice are partners, compared with 65% of men.⁵ A report from the New Zealand Council for Education Research also raises an important issue: that the mostly female teaching profession may have led to the profession becoming less attractive to men.⁶ Evidence also suggests that, with an increasing number of women, the prestige and income associated with the profession is lowered.⁷
- 2.2** In many respects the story of women in medicine in the NHS is a success. In 1948, women accounted for less than a fifth of the medical workforce; today they account for approximately 41% of the workforce, and that figure is rising. Over the past 10 years, women have been increasingly competitive and successful in the medical workforce. Within the overall bubble of expansion of the medical workforce, the total number of women has nearly doubled. With 57% of medical school entrants now women, the medical profession is likely to be the first previously male-dominated profession to achieve parity.
- 2.3** Women with scientific interests seem increasingly keen on medicine. Similarly qualified men choose other scientific careers, particularly information technology and engineering. The proportion of workers in science, technology, engineering and mathematics who are women has barely risen, from 18.4% in 2001 to 18.5% in 2006.⁸ Furthermore, only 25% of women with degrees in these subjects are employed in the respective professions.⁹ In engineering, women make up only 3% of Modern Apprenticeships.¹⁰
- 2.4** Further up the ladder in medical specialties, the number of women becoming consultants is increasing in line with the overall rise in the total number of women joining the medical profession. Nevertheless, whereas at lower grades women account for between 44% and 59% of the workforce, at consultant level they account for only 28%. An attrition rate between the grades is evident, which has remained stable (see **Figure 1**). This is partly due to the function of time, in that as the pool of women grows so too will the number of women at the more senior grades, but given that women have represented 50% of medical students since 1991 the impact should have been greater by now.



Dr Elizabeth Blackwell
First female doctor in the United States

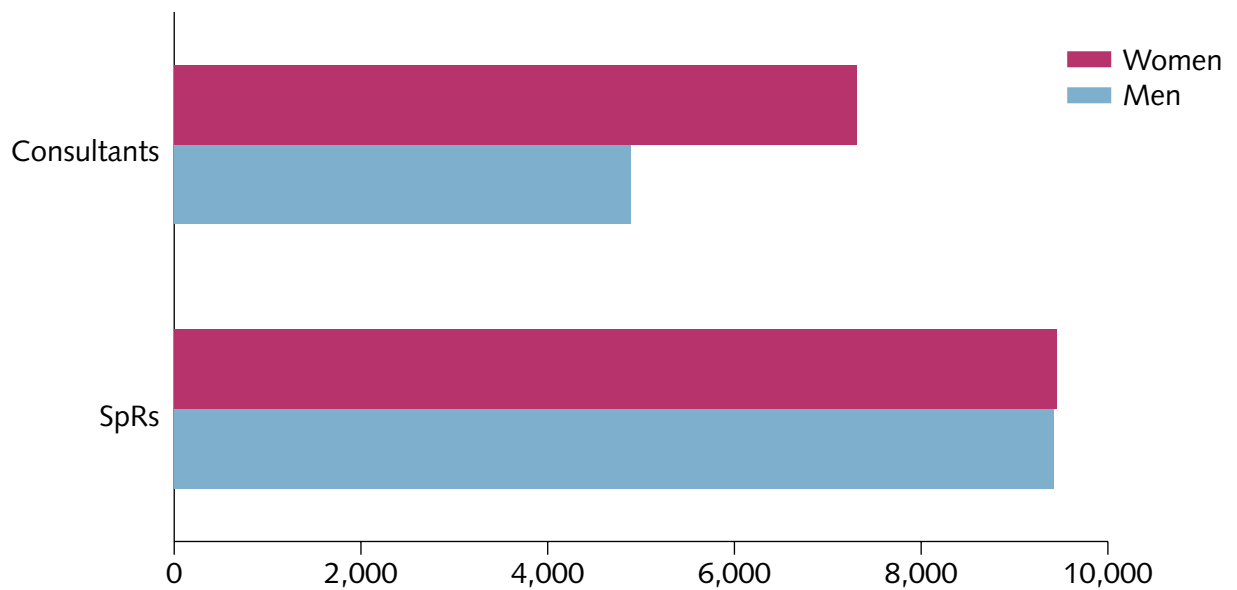
Figure 1: Attrition rates between grades of female doctors as a percentage of the workforce



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

- 2.5** One explanation is that in 2007 the mean age of a mother in the UK for all births was 29.3 years, the age coinciding with the timeframe at which a female junior doctor might be expected to be reaching the final stages of achieving her Certificate of Completion of Training (CCT). Women graduating in the early 1990s would therefore be at the stage of their lives where many are taking career breaks or working part time to care for children. It may thus be that the effect of the 1987 expansion would not be seen for another 5–10 years.¹¹
- 2.6** However, what does seem to be clear is that despite the global increase in the medical workforce, some trends present worrying evidence of a series of obstacles in the system for women. These obstacles seem to be leading women to make decisions regarding their careers that are perhaps compromises rather than choices. These compromises might well deny the medical profession and the NHS of valuable talent and skills in more specialist areas because those obstacles, or perceived obstacles, have not been addressed by those who have the power to address them.
- 2.7** Looking at the number of additional specialist registrars over the last 10 years, for example, shows that the number of additional men appointed and the number of additional women appointed is roughly the same. However, the number of newly appointed consultants in the same period shows a much greater disparity. The increase in doctors' numbers has not been evenly distributed between the sexes at consultant level despite parity having been achieved at the specialist registrar level (see **Figure 2**).

Figure 2: Comparison of the number of additionally appointed male and female specialist registrars, 1997–2007



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

- 2.8** Simultaneously, in the staff and associate specialist (SAS) grades the number of women is disproportionately high. As of 2007, women who graduated from UK medical schools outnumbered their male colleagues and, indeed, female international medical graduates (IMGs). The Royal College of Physicians' report *Women and Medicine: The Future*¹² explains in paragraph 3.60 how the percentage of women in the UK medical workforce may be affected by the numbers of IMGs in the NHS workforce.
- 2.9** In general practice the situation is slightly different. Many women seem to have chosen to move into the specialty in the last 10 years, and the global rise is almost exclusively female. There are also far more women GP registrars than men. General practice is in many ways a success story for women in medicine, with increasing numbers of women choosing this specialty and succeeding.¹³ However, within this overall story lurks a more complex and less positive one. Currently only 46% of GPs are partners; of those who are not partners, 76% would like to achieve partnership. Despite the majority of GPs in partnerships believing that they have a responsibility to make this happen, 66% of GPs believe it is now more difficult to take on new partners. This is borne out by the fact that a majority of GP partnerships (69%) have no or only one partner aged under 40.



Dame Fiona Caldicott
First female president of the Royal
College of Psychiatrists

Figure 3: Comparison of the total GP and GP registrar population, 1997 and 2007



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

2.10 Equally, the number of GP providers has remained the same and the number of GP partners who are women has increased only slightly (see **Figure 4**). GP providers include GP partners, single-handed GPs and GP shareholders.

CASE STUDY: A GP PARTNER MANAGING MATERNITY LEAVE

I joined my practice when I was pregnant with my first child. I was in the 'right place at the right time' as I was doing a locum for a GP who then took early retirement, so the practice was keen to appoint a new partner as soon as possible. There were two partners who were definitely vital in my success in becoming a partner and going on to have four maternity leaves. The male senior partner was a delightful man, much loved by patients and colleagues, and very 'pro women'. There was one female partner, who had managed two pregnancies in general practice and was extremely supportive. I started as a half-time partner, doing five sessions a week and half the on-call commitment. I took four months' maternity leave for each baby and made it clear that I would be coming back. At that time, the maternity payment covered three months of a locum and I paid for the other month. The other two male partners seemed to have no objections.

It was invaluable having another female partner as role model, as a precedent had been set for maternity leave. She was always helpful, on any matter however big or small. After the first maternity leave came and went fairly uneventfully, the partners seemed to manage the next three without a problem. Since then, our practice has seen at least six more maternity leaves, in partners, trainees and salaried GPs. I was always upfront from the beginning, saying that my husband and I wanted to have lots of children, rather than being coy or secretive about it.

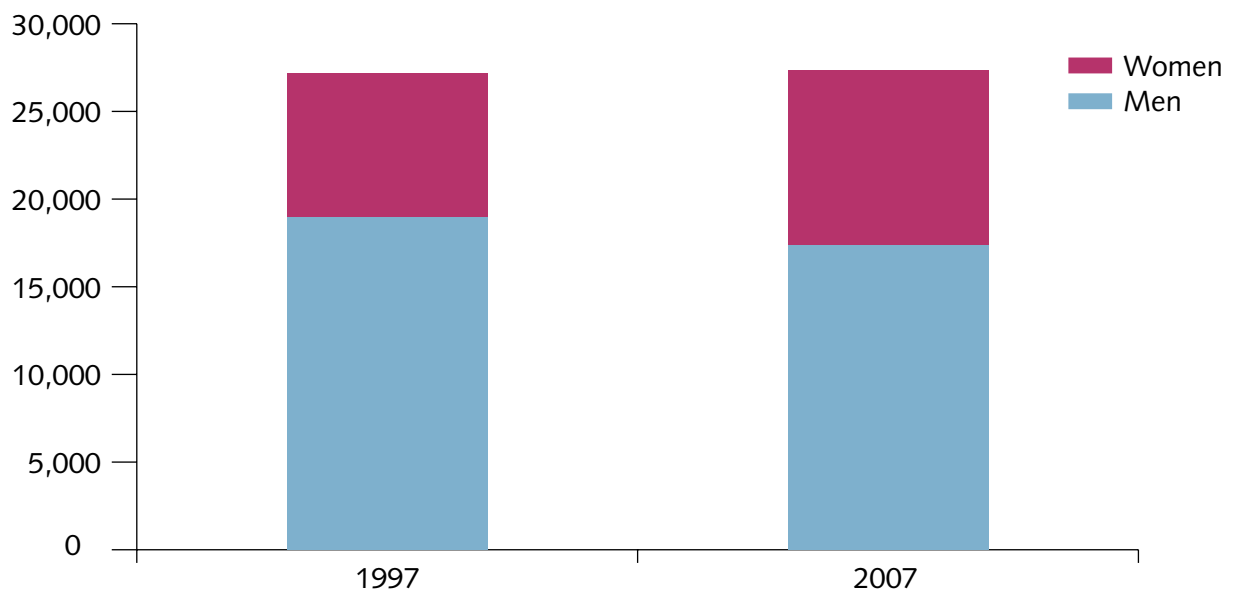
The financial barriers were not huge as I was half time and the maximum grant covered a locum for three months. I was able to feel that I was not a financial burden on the practice. I managed the inevitable problems of small children being ill by having a nanny and a husband, who, as an academic, could be fairly flexible with his working hours. Thankfully my children did not have any special needs, and there were no complications leaving them with a nanny. In the days of on-call at night, the timing could go wrong if a visit clashed with breastfeeding, but we seemed to manage. I am grateful to my husband for holding the fort singlehandedly with four small children on numerous occasions.

My daughter has just finished her first year as a medical student, so what she has seen has not put her off!



Professor Yvonne Carter
Youngest professor of General Practice and Primary Care in the United Kingdom when she took up her post in 1996

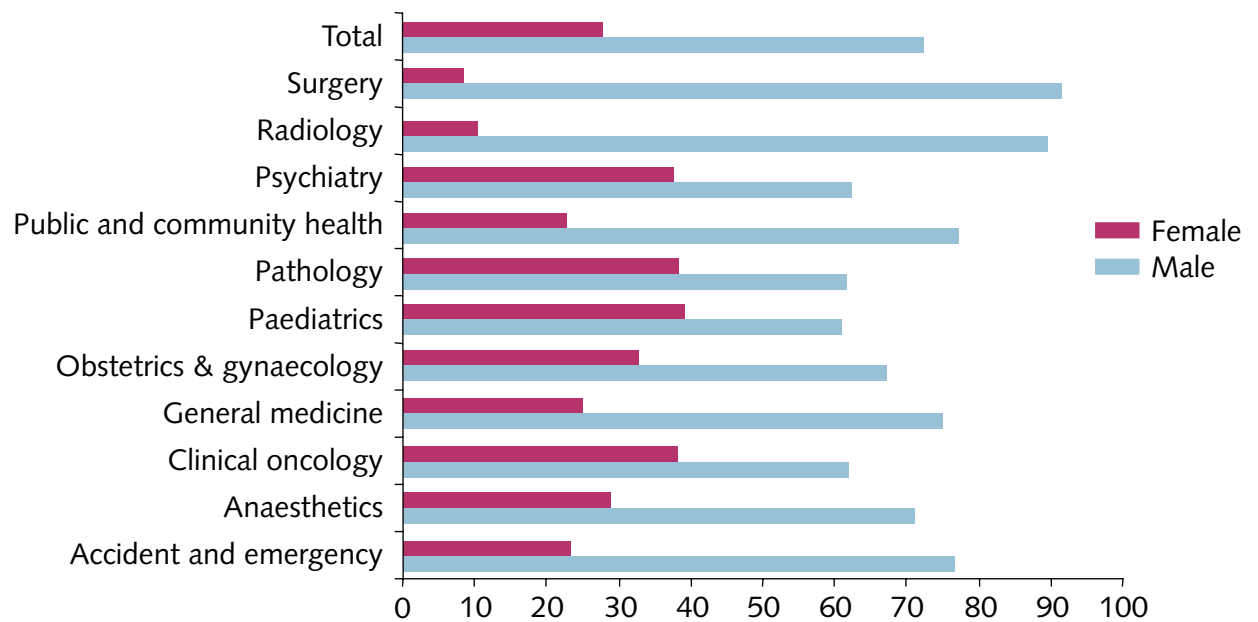
Figure 4: Comparison of the gender breakdown of GP providers, 1997 and 2007



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

- 2.11** For anyone in general practice, being a salaried GP means that employment beyond one year leads to entitlement to full NHS working rights. To avoid bearing responsibility for this, many such practices commonly give contracts for just under a year. Short-term contracts such as this are very disruptive, particularly for those with families. There is additional anecdotal evidence that women are finding it harder than their male counterparts to obtain even these short-term posts.
- 2.12** Furthermore, through schemes such as the Retainer Scheme, and indeed for those coming back to work through the Returners' Scheme, general practice was attractive for women working less than full time, as well as to employing practices. With the reduction of funding that both schemes have seen, these opportunities have dwindled.
- 2.13** Choosing medicine is, of course, only the first of a number of career choices that are faced during the course of a medical career. One of the most crucial decisions that will dictate the subsequent course of a career is that of specialty. Breaking down the hospital consultant specialties by gender reveals a wide disparity between the various specialties in female participation, ranging from less than 10% in surgery to over 40% of the workforce in paediatrics, pathology and psychiatry.

Figure 5: Gender divide (percentage) by specialty amongst the hospital consultant workforce, 2007



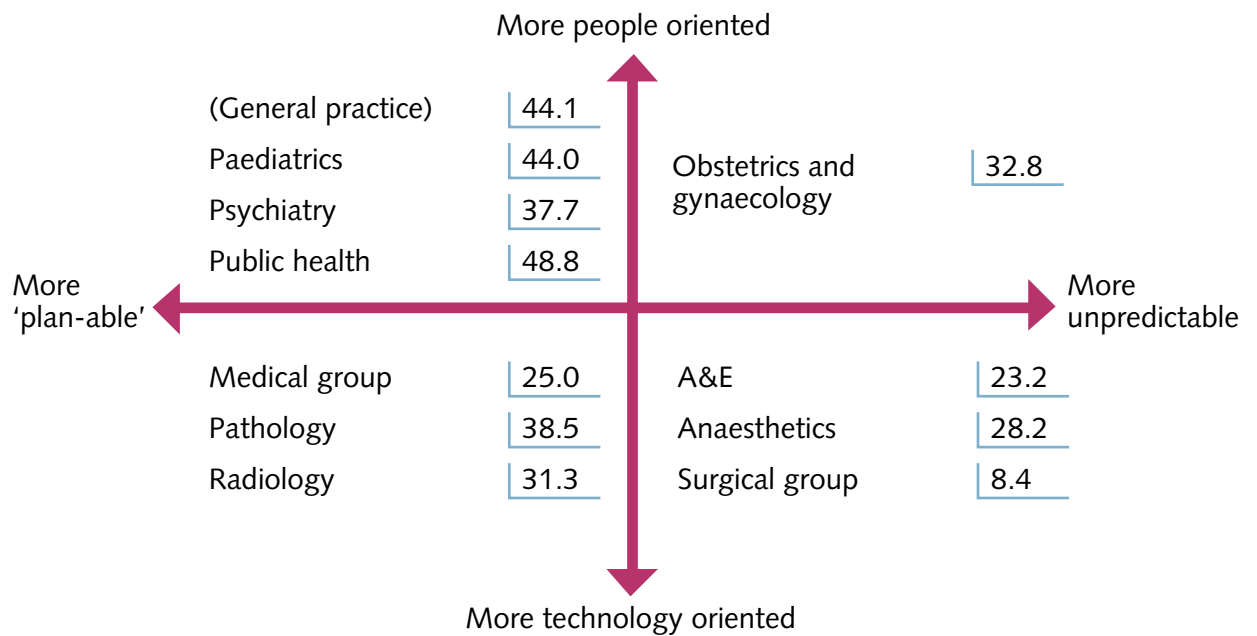
Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

2.14 For men, strong determinants of career or specialty choice are role models prior to medical school, and the opportunity for personal and professional success. Women, however, tend to be influenced more by personal factors such as family obligations, fixed hours and a sense of altruism.¹⁴ This in turn means that different specialties appear attractive to women. Research from the Royal College of Physicians identified that women tend to opt for the 'people-oriented' and 'plan-able'. Nevertheless, this is not always the case, as can be seen by the high percentage of women opting for obstetrics and gynaecology. Conversely, men tend to gravitate towards the more technologically oriented and unpredictable options. For a more detailed explanation, see Chapter 4 of the Royal College of Physicians' report *Women and Medicine: The Future*.¹⁵ Whilst there is no evidence to support the theory that has been raised from time to time that some specialties are more suited to 'male' or 'female' attributes, it is true that some specialties seem to attract proportionately more men than women. This topic could benefit from more research than the group was able to undertake for this report.



Miss Eleanor Davies-Colley
 First female fellow of the Royal
 College of Surgeons

Figure 6: Female share (percentage) of consultant posts by specialty



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)

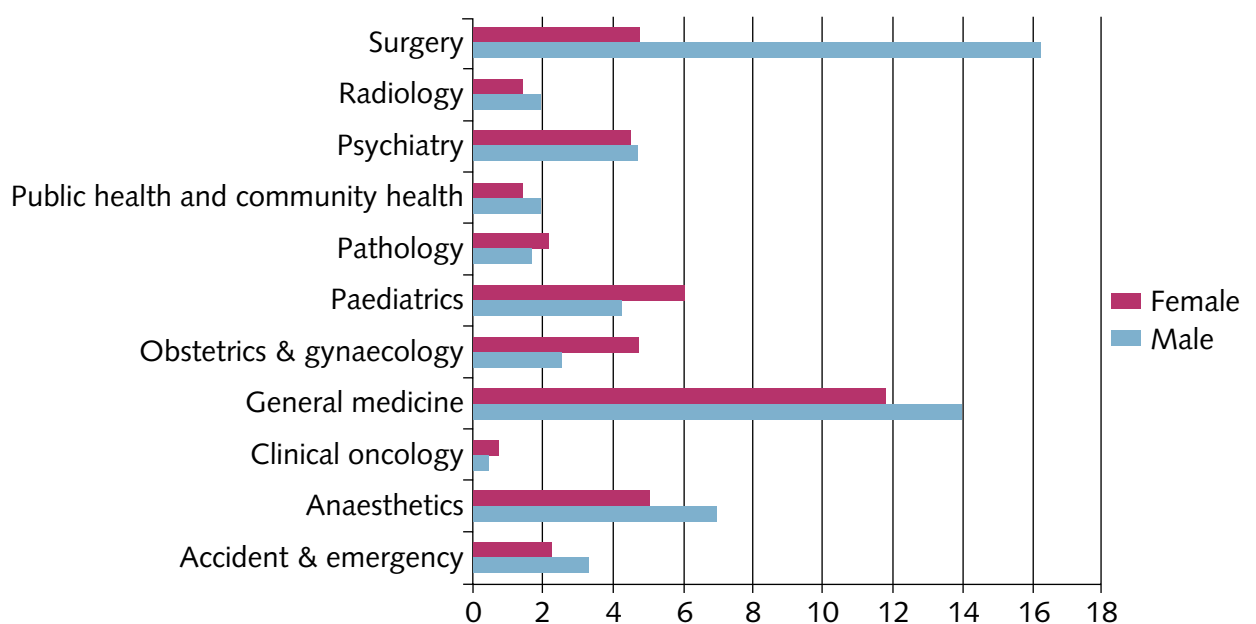
2.15 Surgery is an area of particular concern, given the relatively low percentage of women in such a large specialty (just 8%). However, looking at the data in a different way, there are as many women becoming surgical consultants when including obstetrics and gynaecology, where women represent a third of the specialty. Some caution is therefore required in interpreting the data, and the reasons for lower numbers of women in surgery are not easily discernible, especially as these gender differences are not pronounced at the early stages of a medical career. Indeed, evidence shows that early in their careers, women were as keen on surgery as men; however, men were more likely to follow this through to succeed in becoming fully qualified surgeons. Conversely, looking at specialties in the United States that have more women, although only 8% of women students expressed a preference for paediatrics, a third entered a paediatric residency.¹⁶ Accounting for these changing attitudes through the course of a career is not simple.

CASE STUDY: A FEMALE SURGICAL CONSULTANT

I work full time as a consultant surgeon. I do not have private practice commitments, which means I have a huge amount of flexibility (most of my colleagues have 1.5–2 days a week for their other interests). The new NHS Consultant Contract allows you to negotiate 'supporting professional activities' (eg preparing audits or teaching materials) at home, once the children are in bed. My clinics start at 9.15am, after I have dropped the children at school. I have four children. I recommend living close to work, as you can be on-call from home, with teenage neighbours on standby for childcare if I get called in. I tend to be on-call on Thursdays, so my husband does the school runs on those days.

My parents and in-laws are very helpful for school holidays. I have to be organised – on-line supermarkets can deliver groceries in the evenings. The salary is good enough to pay someone to do ironing and cleaning. My situation as a consultant is better than when I was a trainee, when the hours were still long. As a trainee I had to cope with travelling, exams, using a breast-pump to express breast milk when on-call, and having to fit in with a series of different bosses' timetables. Hopefully, the European Working Time Directive will make it easier for women to decide their specialty without worrying about the hours. You can still think and study when off-duty!

Figure 7: Female and male consultants by specialty as a percentage of total consultant workforce, 2007



Source: The NHS Information Centre for Health and Social Care, NHS Staff 1998–2008 (Medical and Dental)



Mrs Linda de Cossart
Past vice-president of the Royal
College of Surgeons England

- 2.16** The patterns of career choice in specialty training year 1 (ST1) trainees are starting to change. Firstly, overall percentages of women in all specialties are now considerably higher. At ST1 – apart from surgery, which as of 2007 was 27% female, and radiology, which is 42% female – all the specialties are 50% or more female, with the average being 55%. The paradigm is therefore shifting naturally, slowly towards equilibrium. Women are now better represented in the formerly male domains of emergency medicine and anaesthetics, which sit firmly within the bracket of unpredictable working patterns and more technologically oriented fields.^{17, 18}
- 2.17** If these changes are maintained through specialty training, then the workforce will shift to having a female majority. However, as has already been observed, this creates the possibility of a large attrition rate amongst female doctors in the next 5–10 years as choices to favour family are made. The impact on individual specialties will vary, and it is important to note that the context in which women are making these choices is also changing and that it is not entirely predictable how this will affect specialty choice. In particular, the development of credentialling outlined in *High Quality Care for All: NHS next stage review*¹⁹ may well increase the number of women capable of performing, for example, a surgical procedure, but it may reduce the number of consultant surgeons. The effect of a majority female workforce, combined with this more flexible approach to training and certification, may impinge on efforts to create a more consultant-delivered service.
- 2.18** In addition to the choice of specialty and whether to take up a training or non-training post, many women are choosing to work part time. In 2006, 34% of female consultants worked part time compared with 15% of their male counterparts. In general practice, where part-time work is perceived to be easier, as many as 49% of female GPs but only 12% of male GPs work part time. Amongst trainees, part-time working is less easily available, and only 8% of women and 2% of men are in less than full-time training.
- 2.19** Academic medicine also reveals some concerning statistics. In 2007, one in five medical schools had no female professor at all, and only two of the 32 medical schools had a female head. In total, 23.6% of clinical academics are women, whereas women represent 28% of the senior hospital workforce and 36% of general practice providers.
- 2.20** Indeed, within the international context the UK is amongst the countries with the worst representation of women at senior academic level (13% of full clinical professors in the UK are women, compared with 20% in Finland and Portugal). This may represent an extreme subset of the issues outlined earlier in this chapter. Those who enter academia take even longer than men to reach senior levels because academic medicine, with its need for a PhD, is generally worked at concurrently with clinical medicine, thereby lengthening training. This can pose additional hurdles for women.
- 2.21** However, there are a number of other considerations that may mean that the broadly positive vision for medicine in general does not sit neatly with this group. In particular, there is a paucity of women in academic positions who can act as role models. The limited number of women in

positions of authority in medical schools may mean that general trends take longer to reach this subset. Data from some academic centres show that efforts to create networking opportunities and to support, encourage and actively progress women, such as those seen in Sheffield University (the Women's Network) and Queen's University Belfast (the Women's Forum), can dramatically change these patterns. At Queen's University, there has been a gender initiative that includes mentoring. The Women's Forum meets monthly to examine progress. Since 2000, the representation of women on the academic council has increased by 58% and as conveners of appointment panels by 900%. At Sheffield, a women's academic returner scheme has been in place since January 2006 that provides financial support to women returning to work. This support includes funding short-term back-up and a women's network.

- 2.22** Similarly, recent changes to the academic career ladder may help to provide a clear career structure. The introduction of formalised career pathways through the National Institute for Health Research's academic clinical fellowships and academic clinical lectureships, with their clear entry criteria and oversight, may make some of these considerable barriers less imposing.²⁰
- 2.23** Many of the more subtle barriers that seem to be in the way of the progression of women are particularly apparent in academic medicine. Women have fewer failed promotion attempts than men, yet they progress more slowly, implying that women are hesitant to try for promotion and end up waiting longer than perhaps they need to.
- 2.24** In 2009, the Medical Schools Council reported that only 13% of professors in the UK are women, compared with 40% of clinical lecturers. Its survey showed that women often felt they were passed over for promotion and that male colleagues were given projects that are 'more interesting'. Women needed to be more assertive and perceived that having children was considered a further barrier to promotion.²¹ Studies have also reported that women are less likely than men to find an effective mentor.²² This risk aversion is not confined to medicine alone, but it is clearly a powerful factor within medicine.
- 2.25** Similarly, the structural barriers remain in academic medicine, such as the difficulties those working part time have in fulfilling the expectations carried over from full-time work, and the challenges of finding both the time and money for continuing professional development.²³
- 2.26** This trend appears to be reflected in the composition of medical journal editorial boards. A 2006 survey reported that only 9% of female respondents sat on editorial boards – less than half the number of male respondents – and only 2% of female respondents had achieved editorship, a third of the number of their male colleagues.



Dr Elizabeth Garrett Anderson

First woman to gain a medical qualification in the United Kingdom

- 2.27** This apparent dearth of women in senior roles is also recognisable at national level. As of June 2008, only three of the 15 medical Royal College and faculty leaders were women. The British Medical Association (BMA) has never had a female chair of the BMA Council, the executives of its consultant and senior committees are all male, and only three chairs of its 19 committees are women, one of these being a co-chair with a man.
- 2.28** The leadership roles mentioned above are mainly appointed. There is clear evidence that women are less likely to stand for nomination, and that this stems from self-confidence issues and difficulty in squeezing additional responsibilities into an already crowded life. However, women often step into these roles and indeed excel, if they are appointed or stand for election, although reluctant to do so. Women will often not apply for such positions unless actively recruited and encouraged; this may be achieved by women's medical networks publicising vacancies and nominating them for election.
- 2.29** The importance of having women in such roles cannot be overestimated. Not only do holders of these positions help to define the future policy and direction of medicine, but they are powerful role models for those within medicine and, indeed, a signal to those outside medicine.
- 2.30** Despite important changes to the mechanisms for providing reward for service to senior doctors – changes that have made the process more transparent and fair – there has yet to be translation into gain for women. The Clinical Excellence Awards (CEA) scheme indicates that women may not be reaching, or at least are not being recognised for, work at senior levels. In 2008, women accounted for only 16% of applicants to the national award scheme and 17% of the awards given. Overall, twice as many men as women held a CEA at level 9 or above. Selection panels should be gender balanced in order to inspire confidence. Application rates for Silver/Gold Clinical Excellence Awards are lower for females than males (49.5% compared with 55.9%).²⁴ This, too, may be a facet of time, combined with less than full-time working and career breaks. These observations regarding national awards apply equally to local awards.
- 2.31** From these data we can identify trends amongst the female medical workforce:
- Women are more likely to work part time.
 - Women are more likely to enter a staff or associate specialist post.
 - Women are attracted to some specialties over others.
 - Women are very underrepresented amongst senior academics.
 - Women are underrepresented in national leadership roles.
 - Women are underrepresented in the Clinical Excellence Awards scheme.

Chapter 3:

Barriers to success

3.1 Pregnancy and maternity leave

- 3.1.1** For many women the first time their gender affects their working lives is during pregnancy. In addition to the physical effects of pregnancy, there are the complications of changing working practice, both during pregnancy and post-childbirth.
- 3.1.2** The effects of pregnancy are well studied, and there are good data showing that in clinical areas where junior doctors work long hours with periods of sleep deprivation and long periods of alertness there is an increased risk of complications during pregnancy.²⁵ Interestingly, however, these effects appear to be mitigated if maternity leave and training policies are flexible. There is therefore a strong case for ensuring that women have access to flexible work and maternity leave cover, perhaps above and beyond that in other professions.
- 3.1.3** Maternity leave arrangements are legal requirements, but again the complex and varied contractual arrangements in place in the NHS mean that this is an area of confusion and anxiety for women and, indeed, employers. For hospital doctors, the difficulty comes in negotiating their work patterns towards the latter stages of pregnancy without leaving colleagues to carry the additional burden. For GPs the situation is even more complex. The employment arrangements mean that stories of practices not employing females of child-bearing age, or being unable or unwilling to cover the costs of maternity leave, are a cause of serious concern amongst women GPs. The situation seems to be worsening rather than improving, despite efforts from many. Those in substantive academic posts face issues over and above those in the NHS, to do with the length of service in any one particular higher education institution, as maternity rights do not transfer with posts. Collaboration between the NHS and the universities over this was recommended in the Follett report of 2001.
- 3.1.4 Solutions discussed.**
- 3.1.4.1** The European Working Time Directive will go some way to reducing working hours to a nationally consistent standard, but it is important that as the directive is implemented the need for flexibility for pregnant doctors is not lost in the rigidity of the new rotas.
- 3.1.4.2** Serious discussion between the Royal College of General Practitioners (RCGP), the BMA and the Workforce Directorate of the Department of Health needs to be initiated so that the concerns of GPs regarding maternity leave can be understood and managed.



Phyllis George

First woman to be elected to the Council of the Royal College of Surgeons England

CASE STUDY: A PROFESSOR OF DERMATOLOGY

Many of my colleagues in my small specialty (dermatology) were scandalised when I became an unmarried mother at the age of 41. It was difficult combining research with being a single mother and full-time consultant, but the rewards have been great, with a personal chair, a platinum merit award and a son who believes that women are equal and should work.

3.2 Children

- 3.2.1** Of all the issues that have been raised, the most widespread area of concern is that of childcare. A number of individuals and organisations have raised this issue, nationally and internationally, as a key factor in career decisions faced by parents, irrespective of profession. It is accepted that men should play an equal part in childcare and there are some indications that this practice is growing but it has not yet happened, which is why the problems need to be addressed in this report. Our observations and recommendations apply equally to mothers and fathers. For doctors, the demands of childcare affect a number of choices, for example choice of specialty, transfer to a staff or associate specialist grade, retraining, working part time or leaving medicine entirely. Looking after children is an important phase in life, but it is crucial that decisions made at this time do not deleteriously affect future careers.
- 3.2.2** Part of the difficulty concerns the need to balance the developmental needs of children with the career requirements of parents and the requirement of society to gain value for money, given the sums spent on training doctors. Balancing doctors' responsibility to patients against their responsibility to children is all too often a Hobson's choice. Anecdotes of a child being left in the care of a secretary or in the office whilst the needs of a patient are seen to by their doctor-parent are all too common.
- 3.2.3** There are a number of types of childcare, each with its own benefits (see table opposite).
- 3.2.4** No single type of childcare will provide a panacea. Children have different needs as they grow, and doctors also require different levels and types of support as they progress in their careers. The problems in obtaining childcare are different at different stages in doctors' careers, and are dependent on factors such as the ages of their children and their geographic location. It is interesting to note that data from North America and Australia indicate that very shortly half of all physicians will be married to other physicians, making childcare arrangements even more complex.²⁶

Type of childcare	Positives	Negatives
Nannies and home help (live-in/live-out)	24-hour support available One-to-one care	High cost Unregulated Employer responsible for all pre-employment checks/ pay/tax
Nurseries	Ofsted registered Training requirement	Travel costs Usually fixed hours Higher child-to-carer ratio
Childminders	Safe environment Fully regulated Relatively inexpensive Negotiable hours Low child-to-carer ratio	Travel costs Back-up childcare variable Negotiated hours less flexible Site of work
Extended school provision	Good activity set for older children Ofsted registered Holiday provision Relatively inexpensive	Provision variable Travel costs Usually fixed hours
Relatives	One-to-one care Inexpensive	Dependent on availability Reliant on goodwill
Au pairs	24-hour support available Inexpensive	Unregulated High turnover Usually untrained Unsuitable for full-time cover
Babysitters	One-to-one care Inexpensive	Unregulated Dependent on availability



Professor Trisha Greenhalgh
Professor of Primary Care
Health and leading figure in the
philosophical aspects of evidence-
based medicine

CASE STUDY: ALTERNATIVE CHILDCARE

I am a consultant orthopaedic surgeon with four children. My husband is a 'house husband'. It was not our intention to have a complete 'role reversal', but primary school, with holidays and 9am to 3pm days, suddenly seemed much less forgiving than nursery hours. My salary is plenty for a family of six.

The school issue could be worked around differently: two high earners could use private schools with longer school days; alternatively, the consultant job plan includes on-call duty and 10 hours of 'supporting work' in a 40-hour week, so you only have a few fixed early starts and late finishes each week, for which my friends use breakfast and after-school clubs.

I have recently picked up more managerial roles, which involve a lot of evening meetings or sudden changes of priority. Traditionally, consultants' wives were supposed to accept this, but my husband knows that I have deliberately chosen this extra work and resents it a little for the reduction in family time. Once the children can cycle themselves home from school, my husband will be looking to work again. It is a very unusual person who can dedicate their life to bringing up children, and a role that is still undervalued – I know I could never do this.

- 3.2.5** For junior doctors many of the problems arise from the rotational nature of their postings, and the necessity to work unsocial hours, often in changeable working patterns and shift working. For more senior doctors, the problems arise from the unpredictable nature of their on-call and emergency demands, and the long hours that are often worked – not infrequently beyond those paid for.
- 3.2.6** Whilst it may seem that older children pose fewer childcare concerns than infants and young children, this is not necessarily the case. Infants and young children require full-time supervision, whilst those in school require care after school and in the school holidays that, because of the timings, may be more difficult to achieve at reasonable cost. For younger children the questions that parents grapple with concern issues such as where best to place children to ensure that they receive the stimulation necessary for development, whether placement in small or larger groups is more beneficial, and the site of childcare – home vs. the workplace or somewhere else.
- 3.2.7** Equally, the concerns of parents are very much affected by location. Living in cities may bring a wider choice of local childcare options, but the costs may be substantially higher; rural settings have different issues, such as the restricted availability of childcare and the need to travel greater distances.
- 3.2.8** However, all the problems fall broadly into four categories:
- information
 - working practices

- additional provision of childcare
- funding.

Information

- 3.2.8.1** There appears to be a dearth of easily available information. Knowledge seems to pass by word of mouth, and although some trusts and local government organisations do have childcare websites, information is greatly variable. For trainees the problem is particularly acute, because the rotational working pattern, involving frequent moves, makes it even harder to find information about local childcare provision within or near the trust where they are working.
- 3.2.8.2** The information, where it is available, is also not necessarily focused on doctors. Trusts with good practice have a childcare website and a contact number for the local childcare coordinator. However, information is very variable and rarely includes the full range of options available.

Working practices

- 3.2.8.3** One of the key problems with childcare is the unsocial hours worked. The changing patterns of senior consultants' work have led to more doctors working shifts. Senior doctors also suffer from the problem that they may be called on whilst not formally 'on call', and the GMC's *Good Medical Practice* requires a doctor to attend when necessary.²⁷ For junior doctors, more hours are worked outside the normal 9am to 5pm working day, and rotas are now more rigid due to the introduction of the European Working Time Directive.
- 3.2.8.4** The higher number of nurses compared with doctors allows for more flexibility in nurses' rotas than in doctors' rotas. This allows nursing rotas to absorb more readily those staff unable to work unsocial hours because of childcare and caring commitments.
- 3.2.8.5** Provision of longer hours of childcare is one means to address some of these concerns. It is important to stress that longer hours would ensure that facilities are more available at the times required rather than to allow children to be in childcare for longer.
- 3.2.8.6** As mentioned, these problems are compounded for junior doctors by the rotational nature of working – namely, that in most instances a trainee's job changes every four to six months. This means that, in addition to the physical geographical difference in location, accessing employer-based support, such as childcare vouchers, can be incredibly difficult. This situation is compounded by the often short notice at which junior doctors are notified of placements.

Additional provision

- 3.2.8.7** Available workplace childcare is rarely provided outside normal working hours, and even where it is available there is rarely a facility to cover all 24 hours. Given increasing moves for doctors at all levels to work shift patterns, and indeed the increased likelihood of doctors being partnered with



Dame Deirdre Hine
First female Chief Medical Officer
in the United Kingdom

fellow doctors, this places a strain on doctors that is not often replicated in other professions. Similarly, the varied work patterns of doctors make it hard for them to fit into more regimented routines that demand, for example, children's attendance on fixed days. If a doctor's shifts move from a Monday one week to a Wednesday the next, having a place at nursery on a Monday is not helpful. Additionally, for junior doctors moving around on rotations, nursery waiting lists often mean that they cannot obtain what provision is available.

- 3.2.8.8** GPs face different problems: their workplace may not have childcare provision, and they are often self-employed. Careful consideration needs to be given to how current provision of childcare can accommodate their requirements.

Funding

- 3.2.8.9** There is some assistance available to pay for childcare in the form of vouchers; however, this provides a maximum of only £1,195 per annum. The case for additional funds or tax relief for doctors is dependent on clearly expressing that the state requires more from doctors than from other employees and that this additional work impinges on normal childcare. For example, doctors work prolonged unsocial hours, which may be unusually rigid or, conversely, unpredictable. Both of these interfere with simple childcare arrangements, and self-care of children is difficult because career breaks from medicine are damaging due to the loss of skills and knowledge and limited return to work schemes. There will be no real progress towards gaining full value from women doctors until the cost and availability of childcare are addressed. The cost of training alone makes this worthwhile. Above all other considerations, help with childcare will be in the interests of continuity of patient care.
- 3.2.8.10** The costs of childcare are high, the highest of all being employment of a nanny. In addition to the purely financial cost, there are a number of other issues relating to childcare staff that a potential employer has to consider:
- qualifications
 - experience
 - reference checking
 - Criminal Records Bureau checks
 - work permits.

3.2.9 Solutions discussed.

Information provision

- 3.2.9.1** Childcare coordinators in each trust obviously have a key role in disseminating information. The particular challenge is to make that information available as early as possible to trainees who are moving location, either by linking in through the postgraduate deanery or by inclusion in some form of welcome pack for new joiners.
- 3.2.9.2** The Department for Children, Schools and Families has recently published *Next Steps for Early Learning and Childcare*, which places a duty upon local government organisations to manage childcare provision in their area actively. This includes consulting with key employers. It would be difficult to argue that an NHS acute or primary care trust is not a key employer, and trusts that do not currently have childcare provision should exploit this new avenue. Raising awareness of this new duty with trusts will be of key importance. Childcare coordinators in each trust will also have a key role in advancing the needs of doctors, as well as other healthcare staff, in this new framework.

Working practices

- 3.2.9.3** One model that has challenged the constant changes of employer is in the North West, where the deanery acts as the sole employer for trainees regardless of the trust at which they actually work. This minimises the disruption caused by having to start again at each new location in accessing employer-based support.
- 3.2.9.4** Another proposed solution is ringfencing of crèche places for trainee doctors who are moved. However, demand is unlikely to be consistent and modelling work would be necessary to ascertain whether this would be a cost-effective solution.

Additional provision

- 3.2.9.5** Emergency in-trust childcare is also a possible solution for those instances where it is impossible to arrange childcare at short notice for limited periods. Anecdotal evidence of children being minded in a doctor's office by secretarial or other staff is common. However, such practice is not fair on either the child or staff members. If trusts had a 'drop-in' facility, this would provide a safe environment not dependent on the goodwill of non-clinical staff. Again, this would need to be carefully modelled to ensure that it would be cost effective to maintain such a service, and it would need to be reviewed as the European Working Time Directive alters clinical practice.

Funding

- 3.2.9.6** A potential solution to the funding problem would be to allow doctors to pay for childcare out of their gross earnings. This would mean that childcare was treated like the expenses of a small



Dr Sophia Jex-Blake

One of the 'Edinburgh Seven', the first group of female medical students at a university in the United Kingdom. Leading campaigner for medical education for women and involved in founding two medical schools for women

business, and that tax was paid on the net amounts remaining after payment of childcare. This would provide a worthwhile relief from the expense.

- 3.2.9.7** This represents a significant departure from current government policy and would not produce a swift resolution. The process for changing this policy is to require the Department of Health to undertake a detailed business case outlining the benefits of childcare support to doctors and whether it represents value for money. Additionally, the Department will have to demonstrate that doctors are a special case, which it is believed they are by virtue of the length and unpredictability of their working hours. Once the business case has been completed, it will have to be presented to the Treasury as part of the next Comprehensive Spending Review in order to come into effect by 2012.
- 3.2.9.8** The argument might be made – although it would be short-termism – that, in the current financial climate, the cost to the Treasury and the complexity of the arrangements would have to be fully explored and proven to show benefit to the NHS if the Treasury were to approve a change. If a favourable benefit were to be demonstrated, it would not necessarily mean that it would obtain Treasury endorsement. But the expenditure, small in overall terms, would represent the most worthwhile protection of the investment made in training women doctors.
- 3.2.9.9** A second avenue of approach is to ask the Department of Health to make available funding centrally to assist doctors with childcare. This approach also requires a detailed business case being made by the Department's Workforce Directorate and a bid for money in the next Comprehensive Spending Review round. Again, this would face the challenge of competing with other Department of Health priorities against a background of a worsening economic picture. Nevertheless, addressing this issue is the single most productive response called for.*

3.3 Professional barriers

Less than full-time work

- 3.3.1** The thrust of this report is about enabling full-time work in the interests of patients. But data clearly show that both men and women increasingly wish to work less than full time, even with the reduction in hours brought about by the introduction of the European Working Time Directive. This is particularly true during training, when many doctors start families. Equally, with an ageing population it may well be problematic later in doctors' careers too, either in relation to themselves or as carers for family members. Budgets to allow this have increased but are not keeping pace with demand. In part, this stems from the additional cost of employing less than full-time workers, even in job shares. A 2008 survey by the Postgraduate Medical Education and Training Board (PMETB) showed that almost 22% of female trainees report that they want to train flexibly but are not doing so.²⁸

* Although they are not within the remit of the working group, these considerations apply equally to all healthcare workers in similar circumstances.

3.3.2 Less than full-time working is also often undervalued. Previously it was felt that this was because of the supernumerary status of many such doctors, which gave the impression to some that these doctors were less involved and committed to the institutions housing them. A response to this has been to follow the model set by the London Deanery of encouraging job shares where possible. Whilst this has fully integrated doctors into hospital systems, it may have increased rather than decreased problems for those with children or inflexible time constraints. Furthermore, many work less than full time in order to care for others, including ageing and infirm parents, partners and children with long-term conditions or other problems. The effect of this is that these doctors have limited capacity to take on additional work responsibilities, particularly those spread between contracted hours. Accordingly, it is often still felt that women in these positions contribute less to their employers, and this may hamper career progression. A study comparing flexible trainees with full-time trainees found that the outcomes of training were broadly similar: 92% of flexible trainees obtained a CCT compared with 90% of full-time trainees, although flexible trainees were more likely to take part-time consultant posts.²⁹

Re-entering the workforce

3.3.3 It is vital for planning and for the best use of women's talents that their re-entry into the profession be at the forefront of arrangements for maternity leave and afterwards. Many women are choosing to have children at about the age of 30, which is, for a doctor, the latter stage of completing training and becoming able to practise in their own right. It is vital that women have a clear and unambiguous mechanism to step off and then get back on the specialist training ladder, so that the value of the training they have already completed is not lost and that their skills can be topped up on return to full-time practice. One complication is that maternity is an employment issue, meaning that an NHS trust will bear the cost of maternity leave, and yet it is the postgraduate deaneries that coordinate training. Therefore, on returning from maternity leave, a trainee might not return to the trust through which she was previously rotating. This is not financially equitable for the employing trust, and it places an additional burden and uncertainty upon the trainee. Similarly, whilst in the past there has been support for return to work schemes in general practice, such schemes are now very limited, despite many efforts.



Professor Parveen Kumar

Academic gastroenterologist who started the first Master's degree in gastroenterology in England and co-editor of *Kumar and Clark Clinical Medicine*

CASE STUDY: A LETTER ABOUT RE-ENTERING THE WORKFORCE AFTER A CAREER BREAK

Dear Medical Woman's Federation,

I would be very grateful if you could offer me some advice. I am keen to return to medicine after a career break of six years. Prior to stopping work to look after my children, I graduated in 1994 and subsequently spent three years in general medicine and five years in my specialty (the last year was part time, after my first child arrived). Due to the timing of my pregnancies, I sat Part I but not Part II of my membership exams. I also had to voluntarily remove my name from the medical register due to the high cost of fees (unable to be met on a single family income!). I re-registered last year, but due to my extensive time away from work I now have to return to an approved practice setting for one year full-time equivalent.

I am currently researching a number of options.

I am considering returning to my former specialty, although I have to start again at the beginning with my exams, as the system has changed. I am also, of course, somewhat rusty and would need some sort of refresher training.

I have also looked into public health, although it is apparently not possible for me to enter as a doctor, as public health training locations are not approved practice settings. I could apply as a non-medic, although this feels strange as I have a medical qualification, and I can't help feeling that I may be put into a difficult position, having a medical qualification, yet not being allowed to practise as a doctor because I am not in an approved practice setting.

The other difficulty I have is that of fitting my work around childcare. My children will both be at school from September. Unfortunately, I live in a rural area, with no available after-school clubs and very limited availability of childminders. I have no family living nearby who can help.

I know that I can apply for flexible training, but I expect that I would be required to work some full days – due to my lack of childcare, this would prove a challenge!

I know there are no magic answers, but I currently feel very frustrated that my professional experience and qualifications cannot be used, and would be grateful for any advice as to where I can go from here. I understand that there used to be a fantastic returners/flexible scheme run by NHS Professionals, which I believe would have offered the perfect solution, but this does not seem to be available any longer. Is there any alternative?

Non-training grades

- 3.3.4** The decision to step off the training ladder and into a staff or associate specialist (SAS) grade post is made frequently as a solution to balancing the demands of family against work. SAS grades focus on delivering care, releasing a doctor from the structured pressure of training and, indeed, the 'extras' that are required of a consultant. However, once in an SAS grade post, career progression becomes much harder because of the lack of that structure. There is a mechanism by

which SAS grade doctors can demonstrate that they have obtained similar experience to a doctor on a specialist training programme and thus demonstrate eligibility to enter the specialist register. However, the process of constructing a suitable portfolio is time consuming and expensive. In addition, not all deaneries have structured support for SAS grades. The process has been criticised as overly bureaucratic, and, when the medical Royal Colleges provide external assessment of applications, they rely on the goodwill of their senior members to do so on top of their clinical duties. The Postgraduate Medical Education and Training Board (PMETB) regulates the equivalence procedures, and its work with the medical Royal Colleges to reduce delays and improve the process has been recognised.

3.3.5 Part of the problem is, of course, the difficulty in starting any new process. The sheer volume of applications initially caused extensive delays. Additional problems have been associated with the quality of applications, and there have been reports of applicants unnecessarily submitting over 1,000 pages of information. Furthermore, once an application has been rejected, there is insufficient support for that doctor to discover what she needs to do to improve – a void that has been filled by private tutoring companies, which adds to the expense.

3.3.6 However, for women who have chosen the SAS grade, the problem is deeper than simply overcoming the process of application. Achieving a Certificate of Eligibility for Specialist Registration (CESR) gives the impression that the doctor will apply for a consultant post. The reasons determining the decision to enter the SAS grade post in the first place are likely to preclude taking up such a post, deterring application at all. There is a large pool of stagnant talent in the SAS grade as a result.

3.3.7 Solutions discussed.

Less than full-time working

3.3.7.1 Working less than full time, whether to accommodate academic or other responsibilities, also has potential problems for revalidation. All doctors will be expected to be at the same competence level irrespective of hours worked. This is important, as the patient would not want similarly graded doctors with varying competence. However, this requirement means that the onus, cost and responsibility should not fall on the individual to cover the requirements. Less than full-time employees should be entitled to the same continuing professional development and appraisal support as full-time colleagues if they are to be similarly appraised.

Re-entering the workforce

3.3.7.2 With the changes under way in the funding of postgraduate medical education, it would be extremely beneficial, for both the trainee and the employer, if the fragmentation of responsibility for maternity leave could be resolved. A single employer for the duration of postgraduate training



Professor and Senator Rita Levi-Montalcini

Italian neurologist who, with colleague Stanley Cohen, received the 1986 Nobel Prize in Physiology or Medicine for their discovery of nerve growth factor

would greatly simplify the process and allow for much better long-term workforce planning and for the flexibility that is required to make it work.

- 3.3.7.3 In the current mixed economy of run-through and uncoupled specialty training, it will also be necessary to ensure that women in run-through training posts are not disadvantaged compared with those in uncoupled training posts who have, theoretically, a greater opportunity to plan pregnancy during the natural career break between basic and higher specialist training. However, those in uncoupled training posts will have to re-compete for entry to training, whereas those in run-through retain their right to re-enter training where they left off. Work is already under way on the concept of modular credentialling, which should make training more 'portable' and ensure that recognition for achieving competencies is given and appropriately recorded.
- 3.3.7.4 The introduction of revalidation will also impose new challenges, particularly for more senior doctors, as both re-licensing and recertification will be required. Under the proposed arrangements, a long absence from work of over five years could render a doctor unable to practise. It is vital that, as the implementation of revalidation continues, there is clear and unambiguous guidance for doctors on how they can register as 'non-practising' and on the requirements, on a sliding scale dependent on the length of absence, to resume practising again. For a parent of two children it is not inconceivable that a five-year career gap may be necessary. Provisions for 'continuation' training and back-to-work experience will be necessary to assist parents returning to work to demonstrate that they are up to date and fit to practise. The postgraduate deaneries, in conjunction with the GMC and the medical Royal Colleges, will play a key role in this, even for the more senior doctors.

3.4 Psychological barriers

- 3.4.1 The working group heard convincing evidence that women are not reaching the posts they aspire to, not because of structural barriers but rather because of internal psychological differences from their male counterparts. The evidence supports these statements, with women seeming to be restricted by their tendency to be risk averse, non-self-promoting and not as well networked. These less tangible personality facets cannot be altered by recommendations, but rather by local efforts and supportive organisational structures. At the same time, many women told the group that they were happy with a position that fell short of what they might have aspired to, because they had achieved a work-life balance that suited them and gave them fulfilling contact with patients.
- 3.4.2 Experience at the Harvard Brigham and Women's Hospital in Boston, Massachusetts, clearly demonstrates that local action can ameliorate in many ways these more subtle barriers. By creating an Office for Women's Careers, which is actively engaged in the promotion of women to senior positions, they have seen dramatic improvement. Indeed, the number of female professors has doubled.^{30, 31}

3.4.3 Solutions discussed.

3.4.3.1 As trusts and academic institutions coalesce into academic health science centres, there may be opportunities for similar offices in the UK. However, even without these formal structures, the mechanisms that they have used to achieve success can be instituted: identifying female role models who champion local women; providing opportunities to network; mentorship; and active support of promotions. These aims can be simply translated at a local level:

- It is important that every doctor should have her own web page on the trust's site, in order to highlight her profile and make herself known, and in order to help her focus on the achievements that should be recorded.
- Prospectuses and information about the trust should feature women who have succeeded, and they should be put forward as spokeswomen when the trust is publicising its work.
- The practice of hanging portraits of doctors in hospitals and surgeries and learned societies should include those of women, and there should be archives of the achievements of women in the past.
- Women should be selected more frequently to deliver named lectures and keynote speeches at conferences of the BMA and the Royal Colleges, and they should be included in due proportion on editorial committees.
- Committees should meet only at suitable hours, ie not in the early morning or late afternoon when children need collection from school, nor at night when family duties may prevent attendance.
- Mentors should be trained and there should be trust funding for training. Being a mentor should be a positive factor in seeking appointments and awards.
- A leadership programme such as 'Springboard' should be offered to all doctors during their early career, free of charge.
- Women should be encouraged to put themselves forward for awards, locally and by mentors and women's networks as well as in the usual ways. Selection committees should have a gender balance, and proper consideration should be given to part-time applicants.

3.5 The older doctor

3.5.1 Older women doctors often find that they finally have more time to devote to professional duties once their family duties are behind them. In keeping with new laws relating to age discrimination, there should be no age limits on applications for posts, prizes and fellowships. Age limits and criteria such as 'no more than five years from qualification' attached to positions are gender discriminatory, because women are more likely than men to have taken some years off during their careers for family duties. It should be considered whether there should be inducements to women doctors to retire at a later age.

Chapter 4: Recommendations and their rationale

Recommendations	Nominated lead
<p>4.1 Recommendation 1: Improve access to mentoring and career advice</p> <p>4.1.1 In the next round of contract negotiation there should be an explicit facility for appropriately trained and skilled doctors (usually consultants) to undertake mentoring or career counselling as a programmed activity within their job plan.</p> <p>4.1.2 To facilitate accessing mentoring or career management support, the future commissioners of medical education should maintain a register of all doctors who are skilled and are willing to undertake these tasks and make it more accessible to other doctors.</p>	<p>Department of Health Workforce Directorate</p> <p>Dean for Medical Education Commissioning</p>
<p>Rationale</p> <ul style="list-style-type: none"> ● Accessing mentoring or career counselling is currently difficult for a number of reasons. Firstly, these tasks are seen as 'on the side' activities, which are often subsumed by day-to-day clinical concerns. Owing to its informal nature, doctors are only able to access mentoring or career counselling from senior colleagues they know on an almost random basis. When combined with gender issues, this can mean that junior female doctors often gravitate towards the more heavily female-represented specialties, and <i>mutatis mutandis</i> for men. ● A more coordinated approach is needed to ensure fairer and more equitable access to mentoring and career counselling so that it is easier for all doctors to access. ● Creating protected time for consultants and GPs to undertake these activities as part of their job plan would tackle the immediate problem of supply. Placing a coordination role on the future commissioners of education would allow a regional single point of access as well as allowing a strategic view of talent management to be taken. Whilst the commissioners of education are primarily concerned with doctors in training, it will be important that this is also available to doctors post-CCT to ensure that access to career counselling and mentoring can be obtained throughout a doctor's career. 	



Professor Valerie Lund
 First professor of rhinology in the
 United Kingdom

<ul style="list-style-type: none"> ● By providing consultants with the time and space to undertake these tasks, as well as having a regionally based coordination function, the two key outcomes would be as follows: <ul style="list-style-type: none"> – Healthcare provider organisations will be able to supply career counselling and mentorship to doctors throughout their careers. – Career networks can be developed to enhance talent management and development programmes further. ● As part of the annual workforce planning cycle, healthcare providers should declare to SHAs how much mentoring and career counselling capacity is available within their organisation and how many doctors, and at what grade, have accessed the facility. 	
<p>4.2 Recommendation 2: Encouraging women in leadership</p> <p>4.2.1 Appointments to NHS, academic and clinical committees and boards should be advertised widely and have a transparent and democratic process rather than simply an appointment by nomination.</p> <p>4.2.2 Committees should be encouraged to develop their ways of working to enable greater participation by doctors who are parents or carers.</p> <p>4.2.3 There should be increased access for women to the committees and boards of major medical institutions, including the medical schools, postgraduate deaneries, medical Royal Colleges, NHS trusts and other NHS bodies. The Equality and Human Rights Commission should consider auditing the appointments process for all such posts at these institutions, as they consider appropriate, to assess whether sufficient opportunity has been created to increase access for women to these respective organisations' committees and boards.</p>	<p>Presidents of Royal Colleges and other professional institutions</p> <p>Presidents of Royal Colleges and other professional institutions</p> <p>Equality and Human Rights Commission</p>

<p>Rationale</p> <ul style="list-style-type: none"> ● When positions on committees and boards within medical institutions arise, they should be advertised as widely as possible and women should be actively encouraged to apply within a framework of an open appointments procedure. ● Committees tend to operate in the early evening, making it difficult for parents with childcare commitments to attend. A simple solution is to alter their way of working so that committees meet during the day. ● Neither of these proposals can be managed or enforced from the centre. However, the Equality and Human Rights Commission should audit the arrangements that medical institutions have in place for committees and boards and publish the results, using openness as a lever for change. 	
<p>4.3 Recommendation 3: Improve access to part-time working and flexible training</p> <p>4.3.1 The postgraduate deaneries should maintain a list of doctors wishing to train part time in a slot-share arrangement.</p> <p>4.3.2 NHS Employers should develop guidance for meeting the costs of continuing professional development, including for those who are working less than full time.</p> <p>4.3.3 The development of credentialling should be expedited, and there should be full recognition by the medical Royal Colleges that time alone does not indicate competence to practise independently.</p> <p>4.3.4 The aspirational quota for part-time training should be abandoned in favour of a needs-assessed availability by strategic health authorities (SHAs). The newly formed Centre for Workforce Intelligence should be commissioned by each SHA to provide this needs assessment on a regional basis, and provision should be made to meet it.</p>	<p>Deans of postgraduate deaneries</p> <p>Trusts</p> <p>Presidents of Royal Colleges and other professional institutions</p> <p>Chief executives of SHAs</p>



Professor Averil Mansfield
 First female professor of surgery
 in the United Kingdom

<p>Rationale</p> <ul style="list-style-type: none"> ● Part-time training and working is perhaps the best solution to balance work and family. The current part-time arrangements are extremely variable and largely depend on doctors who wish to work part time having the good fortune to meet another doctor in the same position. A more coordinated approach, with the postgraduate deaneries being able to 'match' doctors wishing to work part time, will greatly improve the situation. ● The progress of medical education towards modular credentialling is an important and extremely welcome move. It will facilitate movement in and out of training, which will be of great benefit to women who are planning to become mothers. ● Current part-time working arrangements are based on an aspirational quota of availability, which is neither achievable nor realistic. Different workforces will have different demographics, and the key is to ensure that any demand for part-time working can be facilitated, so that doctors do not have to make choices such as changing specialty, moving into the SAS grade or leaving the profession entirely. By assessing the need in each region, SHAs will then be able to include planning for part-time training in their annual workforce planning cycle. 	
<p>4.4 Recommendation 4: Ensure that the arrangements for revalidation are clear and explicit</p> <p>4.4.1 The General Medical Council (GMC) and the appropriate medical Royal Colleges should ensure that they have a clear set of re-licensing and recertification standards and assessment processes in place for doctors who have taken time out of training or the profession to return to work.</p> <p>4.4.2 Responsible officers should coordinate refresher training for those who have taken time out of training to meet these standards. There should be funding for this within the NHS budget.</p> <p>4.4.3 Trusts should offer 'back-to-work' and 'taster' sessions where those who have taken a career break can shadow working doctors to re-familiarise the doctor with procedures and work patterns, so that they are confident on return.</p> <p>4.4.4 The Postgraduate Medical Education and Training Board (PMETB) and the GMC should ensure that women in non-training grades receive support in applying for entry to the specialist register.</p>	<p>GMC and presidents of Royal Colleges and other professional institutions</p> <p>Chief executives (CEs) of trusts</p> <p>CEs of trusts</p> <p>PMETB and GMC</p>

<p>Rationale</p> <ul style="list-style-type: none"> ● Revalidation will present a new challenge for doctors who take time out of work. Whilst a short career break, such as a year, is unlikely to impinge on the five-yearly revalidation cycle, a longer break may well present difficulties. It will be important that the GMC and the medical Royal Colleges have a clearly laid out process for doctors who do take longer career breaks so that they can re-enter practice safely. ● This will need to be supported locally with the appropriate retraining or supervisory arrangements, so that the GMC, the NHS organisation, patients and the public can be assured that returning doctors are up to date and fit to practise. ● Doctors who are thinking about returning to work after a career break should be supported in that decision by the provision of 'back-to-work' or 'taster' sessions, where they can shadow a working doctor so that they can refresh their skills and understand the process they will need to undergo in order to return to work successfully. 	
<p>4.5 Recommendation 5: Women should be encouraged to apply for the Clinical Excellence Awards scheme</p> <p>4.5.1 The Advisory Committee for Clinical Excellence Awards (ACCEA) should provide greater feedback to applicants and advice as to where additional development might be necessary.</p> <p>4.5.2 ACCEA should develop a network of mentors who can be approached for advice. This should be coordinated with the wider career advice programme.</p> <p>4.5.3 Selection panels should be gender balanced wherever possible; due consideration should be given to part time applicants and ACCEA's processes should be monitored for gender equality.</p> <p>4.5.4 The same encouragement should be applied to local awards, if any, and monitoring information from all trusts should be collected centrally for gender analysis.</p>	<p>ACCEA</p> <p>ACCEA/trusts</p> <p>ACCEA/trusts</p> <p>Trusts</p>



Miss Clare Marx
 First female president of the
 British Orthopaedic Association

<p>Rationale</p> <ul style="list-style-type: none"> To tackle the underrepresentation of women applying for a Clinical Excellence Award, more support is needed to provide advice both on how to make an application and, following a failed application, on where development is needed. By developing a feedback function that gives a detailed appraisal of the application as well as anonymised comparator data, doctors will be able to ascertain where they need to develop their practice. By combining this with signposting as to where a doctor can find further advice, doctors will be encouraged to revisit their application instead of simply giving up, and to improve their practices where necessary, providing the spur to improvement of the quality of their service. This will benefit all doctors attempting to obtain a Clinical Excellence Award as well as the patients they treat. Women are receiving fewer awards than they should; a gender balance on the panel would inspire more confidence in the result. 	
<p>4.6 Recommendation 6: Ensure that the medical workforce planning apparatus takes account of the increasing number of women in the medical profession</p> <p>4.6.1 NHS Medical Education England (NHS MEE) and the Centre for Workforce Intelligence should ensure that workforce models for the future clearly delineate the effect of a rising number of women in the workforce so that appropriate advice for the workforce planning apparatus can be given.</p> <p>4.6.2 For training, NHS MEE should commission the medical Royal Colleges to develop innovative solutions to these challenges. It is noted that NHS MEE is conducting a review into the challenges that are presented by the European Working Time Directive, to improve the quality of training in reduced training opportunity circumstances, and this should address the particular issues for women.</p> <p>4.6.3 The Centre for Workforce Intelligence should approach the GMC to discuss ways of tracking careers effectively through GMC numbers to allow accurate data to be collected to inform workforce modelling.</p>	<p>Department of Health Workforce Directorate to work with NHS MEE and the Centre for Workforce Intelligence</p> <p>NHS MEE</p> <p>Centre for Workforce Intelligence</p>

<p>Rationale</p> <ul style="list-style-type: none"> ● The expansion of medical school places has brought about a large increase in the number of women entering the profession. Given the current trends for women choosing to enter certain specialties or grades, working part time or taking breaks from their career, it is vital that the workforce planning apparatus takes into account the effects of more women in the workforce now and actively manages those changes. ● To understand this issue fully, there needs to be an effective tracking mechanism for doctors' careers. One potential method is to use the GMC number to follow a doctor through her career; however, due consideration needs to be given to the legal limitations imposed by data protection, and the Centre for Workforce Intelligence should approach the GMC to open a discussion. ● In combination with other factors – such as the European Working Time Directive, the move towards greater provision of care in the community, the ageing population and greater patient expectation of access and choice – the pressures to ensure the right supply are extremely challenging. A responsive planning system is required, which is capable of identifying trends and mobilising partners, such as the medical Royal Colleges, to create innovative ways to equip doctors to meet the demand, including the development of simulation techniques and e-learning. 	
<p>4.7 Recommendation 7: Improve access to childcare</p> <p>4.7.1 The Conference of Postgraduate Medical Deans of the United Kingdom and the Department of Health should consider whether the model such as that in place in the North Western Deanery, which commissions a lead employer for all specialty trainees in the deanery, would be a practical and desirable model in the new education commissioner/ provider landscape. The additional benefit of better facilitating access to government assistance for maternity benefits and childcare of this model is clear.</p>	<p>Conference of Postgraduate Medical Deans</p>



Dr Edith Pechey-Phipson
 One of the 'Edinburgh Seven',
 the first group of female medical
 students at a university in the
 United Kingdom

<p>4.7.2 Postgraduate deaneries or their lead employers should plan ahead for the childcare needs of their trainees and facilitate arrangements between a trainee and the trusts during his or her rotation for access to childcare provision.</p>	<p>Deans of postgraduate deaneries or lead employers</p>
<p>4.7.3 Trusts should appoint a childcare coordinator within their human resources department if they have not yet done so.</p>	<p>Trust human resources departments</p>
<p>4.7.4 Childcare coordinators should develop internet resources to act as both an information resource and message boards on local childcare options, including emergency cover.</p>	<p>Trust childcare coordinators</p>
<p>4.7.5 NHS trusts should engage with local authorities as key employers to ensure that local authorities fulfil their legal responsibility to ensure that the childcare needs of their population are met. NHS Employers should begin a programme of work to advise and coordinate NHS trusts to achieve this and help spread best practice.</p>	<p>Trust human resources departments</p>
<p>4.7.6 NHS Employers should draw up guidance on good practice on what additional provision NHS trusts should make for childcare allowances for unavoidable unsocial hours of work.</p>	<p>Trust human resources departments</p>
<p>4.7.7 Hospital-based childcare should move to extended opening hours. NHS Employers should host a conference of childcare coordinators with the objective of identifying how this and the specific needs of doctors can be achieved.</p>	<p>Trust human resources departments</p>
<p>4.7.8 The Department of Health should explore the costs and benefits of doctors (and other healthworkers in similar circumstances) who are parents paying for full-time or part-time childcare as a value-for-money solution for enabling doctors to progress their careers. On the basis of this analysis the Department should submit a case to the Treasury to allow doctors to pay for childcare from their gross earnings. In addition, it should establish whether any central funding might be available for childcare assistance. The working group believes that this is fundamental to ensuring that all doctors can fulfil their potential</p>	<p>Department of Health Workforce Directorate and Finance Directorate</p>
<p>4.7.9 The Centre for Workforce Intelligence should urgently model the effects of greater female participation in general practice and the potential costs of maternity cover. Contractual changes should be considered based on this modelling to compensate maternity leave should it be required.</p>	<p>Centre for Workforce Intelligence</p>

<p>Rationale</p> <ul style="list-style-type: none"> ● Improving the availability and accessibility of childcare is a key enabler to ensure that doctors who want to progress their careers are better able to do so. No single childcare solution will be right for everyone; however, there are a number of options to position doctors so that they are better able to exploit the provision that is already available. By altering ways of working and providing additional funding, there may be further opportunities to improve the situation. ● The primary obstacle for trainees is the rotational pattern of their working arrangements. By forward planning, the postgraduate deaneries can greatly reduce the stress of childcare by coordinating a trainee's needs with the trust. The single-employer model would also realise the benefits of allowing trainees to access childcare vouchers much more easily and eliminate the need to constantly reapply each time they move post. ● All doctors who are parents would benefit from easier access to information and a trust-supported network of parents. Not only would this act as a focal point for doctors who are parents and allow <i>ad hoc</i> emergency arrangements to be made more easily and quickly, it would also ensure that parents are not isolated. ● Given the sometimes unpredictable nature of providing healthcare 24 hours a day and, for consultants, the potential need to attend even when they are not 'on call', childcare provision for extended unsocial hours is essential. ● The issue of funding childcare should be investigated fully to establish the costs and benefits of making essential additional provisions in this area. 	
<p>4.8 Recommendation 8: Improve support for carers</p> <p>4.8.1 All postgraduate deaneries or their nominated lead employers and NHS trusts should have a lead person responsible for supporting carers.</p> <p>4.8.2 The NHS should join Employers for Carers and benefit from the financial advantages conferred when adopting carer-friendly employment practices. Doctors who are family carers have particular difficulties with long, unpredictable and inflexible hours of work.</p>	<p>Postgraduate deaneries or lead employers, NHS Directorate and NHS trusts</p>



Professor Dame Julia Polak
 One of the longest-living survivors post-heart and lung transplant in the United Kingdom and a leading figure in research on tissue engineering

<p>Rationale</p> <ul style="list-style-type: none"> ● With an ageing population, the number of doctors acting as carers at some point in their careers will increase. Whilst as a caring profession medicine inherently understands the demands of such dual responsibility, it will require special efforts to ensure that doctors acting as carers are not disadvantaged. The working group explored the challenges that carers face and how these demands affect both career patterns and day-to-day life. The overwhelming sense from the group was that many of these challenges could be overcome by increased awareness, flexibility and defined routes for support. ● The Work and Families Act 2006 gives to employees who are carers the right to request flexible working. Employers must seriously consider such requests and can only refuse for one of the business reasons set out in the legislation. The NHS should follow the best practice guidelines prepared by Carers UK. 	
<p>4.9 Recommendation 9: Strenuous efforts should be made to ensure that these recommendations are enacted through the identification of champions</p> <p>4.9.1 Trusts should identify a non-executive director to have responsibility at a local level for improving working patterns, giving advice and handling complaints. The director should work closely with a lead consultant for workforce planning.</p> <p>4.9.2 Royal Colleges should follow the example of the Royal College of Psychiatrists and develop gender equality plans.</p>	<p>CEs of trusts</p> <p>Presidents of Royal Colleges and other professional institutions</p>
<p>Rationale</p> <ul style="list-style-type: none"> ● Without a designated individual responsible for bringing these recommendations to board level, there will be limited leverage to effect change. Similarly, Royal Colleges can provide moral weight and set good examples by their actions. 	

Annex 1: Recommendations of previous reports

Report	Date	Recommendations
<i>Women and Medicine: The Future</i> , Royal College of Physicians	2009	<p>Examine requirements for workforce design:</p> <ul style="list-style-type: none"> ● The organisational implications of changing workforce patterns and preferences with respect to working hours and specialty choices should be urgently examined so that the effective delivery and continuity of patient care is not compromised. <p>Investigate economic implications of changing workforce patterns:</p> <ul style="list-style-type: none"> ● The funding consequences of a potentially substantial increase in part-time and other forms of flexible working require detailed analysis so that the level of possible future budgetary commitments can be better understood. <p>Address critical information gaps:</p> <ul style="list-style-type: none"> ● There exists the need to strengthen the adequacy and accessibility of cross-sectional and longitudinal data on the working patterns of doctors. ● More information and research are needed on entry to the profession. <p>Strengthen workforce planning and modelling:</p> <ul style="list-style-type: none"> ● The implications of differential working preferences of women and men over their career lifetimes should be modelled to test sensitivities with respect to changing average participation rates, the scope for further extension of part-time options, and the core requirements for continuity of patient care. ● Analysis is needed to investigate the longer-term impact on the balance of supply and demand across individual specialties and on total service capacity. <p>Enhance career guidance and feedback:</p> <ul style="list-style-type: none"> ● More guidance should be given to help trainees achieve a sound assessment of the relative competitiveness of entry to different specialties. ● There exists a need to ensure that at later career stages appropriate counselling and feedback can be offered, especially for women doctors, on the development of leadership skills, and on the commitments required for attaining the highest levels within the profession.



Dame Cicely Saunders
 Founder of the modern
 hospice movement

Report	Date	Recommendations
<p><i>Making Part-Time Work, Medical Women's Federation (MWF)</i></p>	<p>2008</p>	<p>Recommendations on attitudes to part-time working:</p> <ul style="list-style-type: none"> ● The medical profession needs to promote more positive attitudes to part-time working through mentors, role models and case studies. ● Royal Colleges, deaneries, the BMA and the GMC need to find effective ways to consult with those doctors working part time on a wide range of issues. <p>Recommendations on part-time training posts:</p> <ul style="list-style-type: none"> ● Employers and Royal Colleges should work together to ensure that rota design can routinely incorporate part-time workers. ● Medical directors should support and promote innovative job design. ● Deaneries should ensure that training programme directors take responsibility for leading integration of part-time trainees into training programmes. ● Deaneries and employers should continue to build on the progress of mainstreaming part-time training. ● Employers, deaneries, training programme directors and educational supervisors should ensure a prompt and sympathetic response to those trainees who express a desire to train part time. ● Junior doctors should be made more aware of sources of information and support for part-time training at undergraduate and postgraduate level. <p>Recommendations on part-time career grade posts:</p> <ul style="list-style-type: none"> ● Royal Colleges should issue guidance on part-time career grade posts. ● Medical directors should support and promote innovative job design in order to encourage part-time working for consultants and SAS grade doctors.

Report	Date	Recommendations
		<p>Recommendations on career development for part-time doctors:</p> <ul style="list-style-type: none"> ● Employers, medical directors and deaneries should adopt a formal approach for the reacquisition of clinical skills after a career break or a period of extended leave. ● The MWF should seek to work with key stakeholders to promote successful examples of part-time working in the medical profession. ● Deaneries, Royal Colleges and the BMA should work with PMETB to use the national survey of trainees to explore any systematic differences in the quality of training experienced by those in full-time and part-time posts.
<p><i>Women in Clinical Academia: Attracting and Developing the Medical and Dental Workforce of the Future</i>, Medical Schools Council</p>	<p>2007</p>	<p>Students:</p> <ul style="list-style-type: none"> ● More comprehensive information to students ● Mentoring ● Experience of research early on ● Formal instruction on how to teach <p>Flexibility:</p> <ul style="list-style-type: none"> ● Recognition of need for career breaks ● Recognition of need for flexible working ● Dedicated tenure tracks for clinical academics ● Career tracking through funding bodies ● Flexible training reinstated in deaneries ● Participation in senior leadership training encouraged ● Monitoring by Royal Colleges and medical schools of representation on panels, boards and faculty positions



Dr Fiona Subotsky
 Past president of the Medical
 Women's Federation and
 consultant child and adolescent
 psychiatrist

Report	Date	Recommendations
<i>Women in Academic Medicine: Developing equality in governance and management for career progression (Athena Project)</i> , Higher Education Funding Council for England, Medical Schools Council, Imperial College London, MWF, BMA	2007	<ul style="list-style-type: none"> ● Both the promotions criteria and process need to be made explicit and transparent to all staff. ● Appraisal should be an annual process and timed to fit in with the promotion cycle. ● Appointments committees should reflect the diversity of staff required (eg women and ethnic minority groups). ● Gender monitoring of appointments and promotions should be in place. ● Equal opportunity and diversity training should be provided. ● Mentoring for women should be mainstreamed and monitored. ● Role models and networking should be recognised and encouraged. ● Measures of gender equality should be benchmarked against European targets and exemplars.

Report	Date	Recommendations
<p><i>Women in Hospital Medicine: Career choices and opportunities</i>, Report of a working party of the Federation of the Royal Colleges of Physicians</p>	<p>2001</p>	<ul style="list-style-type: none"> ● More opportunities for part-time consultant posts. ● More flexibility in the number of sessions worked over the time an individual holds a particular consultant post. ● More part-time training opportunities. ● Increases in job shares. ● A flexible training budget should be determined by the percentage of female graduates and there should be interchange between the training budgets so as to provide more part-time training posts for all deaneries and movement between geographic areas. ● Training should be competency based. ● Appropriate training should be made available to non-consultant grade post holders so they can apply for consultant positions. ● Improved mentoring from medical school through to specialty selection overseen in the later stages by the appropriate college. ● Educational opportunities should be available to those who do not work standard hours. ● The introduction of a hospital retainer scheme similar to that offered in general practice. ● Appropriate support for those who have stepped out of medicine and want to return. ● Adequate childcare places with out-of-hours provision should be available within the NHS. ● Pension rights for part-time workers and those with career breaks should be reviewed. ● Grant allocation should be irrespective of working hours. ● Specific part-time academic posts are necessary. ● There should be equity of representation of women on academic boards and grant-awarding bodies. ● There should be equal opportunity for nominations for distinction awards. ● There should be equal opportunities for women to apply to academic and senior management posts.



Dame Margaret Turner-Warwick
 First female president of the Royal
 College of Physicians

Report	Date	Recommendations
<p>Report to the NHS Executive, <i>Making it happen: Part-time, flexible and portfolio careers in hospital medicine</i></p>		<ul style="list-style-type: none"> ● A work–life balance is necessary for all doctors if they are to survive fruitfully in clinical work today: this need must be recognised by the NHS. ● Professional and personal ambition and the desire to work flexibly are not incompatible. ● Most of the leaders of the profession already have a ‘part-time’ clinical commitment and combine it with other nationally important work. Other reasons to work less than full time in the NHS need to be given comparable status and respectability. ● A variety of working patterns needs to be facilitated and actively promoted in the NHS. This would help retain highly skilled staff throughout their careers, whatever their other commitments. The wider responsibilities and contributions expected of a consultant need to be recognised when job plans are organised so that all consultants can participate fully in the clinical and managerial life of a department. ● To enable more flexible working patterns to come about there will need to be planning and investment of money in different ways of working and a willingness to change accepted practices whilst maintaining high professional standards. ● Current equal opportunity legislation may make it easier for an individual to get a job, but by inhibiting discussion of a consultant’s other responsibilities or needs (disability or chronic illness), may make it less practical to carry it out. It must become possible to state and openly negotiate these in order to make successful completion of the job a reality. ● The retainer scheme and the possibility of career breaks for hospital doctors should be enhanced. ● Making it possible to move from clinical assistant and SAS grade jobs into consultant jobs, with appropriate specialist registrar training, would enable better use of resources. ● In order to retain very senior doctors, who now may return to work in their mid-50s or at 60, the NHS should consider facilitating flexible exit from a consultant post as well as flexible entry into it. ● The culture of medicine is changing with changes in society. With increased public expectations and greater scrutiny by outside agencies, doctors will be expected to give more of themselves in their encounters with patients.

Annex 2:

Terms of reference of the National Working Group on Women in Medicine

- To review existing work and the most recent reports published on individual aspects of this larger problem.
- To consult the opinions of the medical profession.
- Drawing on this work, to recommend a programme of action to improve opportunities for women in medicine.

Annex 3: Chair of the National Working Group

Baroness Ruth Deech



Ruth Deech taught law at Oxford University and was Principal of St Anne's College there from 1991 to 2004. From 1994 to 2002 she chaired the Human Fertilisation and Embryology Authority, and from 2002 to 2006 she was a Governor of the BBC. She was the first Independent Adjudicator for Higher Education from 2004 to 2008, and since 2009 she has chaired the Bar Standards Board, the independent regulator of barristers. She is a fellow of the Royal Society of Medicine. Appointed to a life peerage in 2005, she sits as a crossbencher.

Annex 4:

Membership of the National Working Group



Professor Dame Carol Black
National Director for Health and Work

Besides being a National Director, Dame Carol is also Chair of the Nuffield Trust, President of the British Lung Foundation and Pro-Chancellor at the University of Bristol. She is the immediate past President of the Royal College of Physicians and has just stepped down as Chair of the Academy of Medical Royal Colleges. The internationally renowned centre she established at the Royal Free Hospital, London, is the major centre in Europe for clinical care and research on fibrosing connective tissue diseases, in particular systemic sclerosis.

Since the early 1990s, Dame Carol has worked at board level in a number of organisations, including the Royal College of Physicians, the Royal Free Hospital Hampstead NHS Trust, the Health Foundation, the NHS Institute for Innovation and Improvement and the Imperial College Healthcare Charity. She recently served as Chair of the UK Health Honours Committee and is now on the main committee for the Queen's Awards for Voluntary Service. She is also a member of many national committees aiming to improve healthcare. She is a Foreign Affiliate of the Institute of Medicine USA and has been awarded many honorary degrees and fellowships.



Professor Jane Dacre
Professor of Medical Education, leading on Women in Medicine for the Royal College of Physicians

Jane Dacre is Director of the Division of Medical Education within the Faculty of Biomedical Sciences at University College London and Vice Dean of its medical school. She is a consultant physician and rheumatologist at the Whittington Hospital NHS Trust in London and is a former Academic Vice-President of the Royal College of Physicians. Professor Dacre took up her first consultant post as a rheumatologist in 1990 and was a lead clinician in the development of the first Clinical Skills Centre in the UK. She has continued to develop expertise in medical education (redesigning several clinical examinations) and rheumatology in parallel. Her current academic interest is in the training and assessment of doctors in general, including fitness to practise, and rheumatologists in particular. She has been appointed to the new GMC Council and is a non-executive director of the Whittington Hospital NHS Trust. She is married with three children.



Professor Dame Sally Davies
Director General of Research and Development, Department of Health

Professor Dame Sally Davies is the Director General of Research and Development and Chief Scientific Adviser for the Department of Health and NHS. As Director General, she developed the new government research strategy, Best Research for Best Health, with a budget rising to £1 billion, and is now responsible for implementation of the National Institute for Health Research (NIHR). She is a board member of the Office of the Coordination of Health Research and the Medical Research Council and chairs the UK Clinical Research Collaboration.

She led the UK delegations to the World Health Organization (WHO) Ministerial Summit in November 2004 and the WHO Forum on Health Research in November 2008. She is a member of the WHO Global Advisory Committee on Health Research and chaired the Expert Advisory Committee for the development of the WHO research strategy. She is a member of the International Advisory Committee for A*STAR, Singapore, and the Caribbean Health Research Council Board, and she advises many other groups on research strategy and evaluation, including the Australian National Health and Medical Research Council.



Dr Clarissa Fabre
Medical Women's Federation

Dr Clarissa Fabre is President Elect of the Medical Women's Federation. She is a full-time GP in East Sussex. She initially trained in paediatrics but moved to general practice after the birth of three children and a career gap of seven years. Her surgery has changed from being a sleepy single-handed village practice to a three-partner, part-dispensing, training practice with two registrars and two part-time salaried doctors.

She has been active in medical politics for many years, on the local medical committee and, for a spell, on the Professional Executive Committee of the local primary care trust. For the past four years she has represented both East and West Sussex GPs on the British Medical Association's General Practitioners Committee.

She joined the Medical Women's Federation (MWF) when barriers appeared in her career, with few opportunities for flexible training in paediatrics and geographical isolation. The most important objective of her involvement in MWF is to ensure that women doctors are provided with the opportunities to combine a fulfilling family life with maximum achievement in their professional careers. She is married to a medical academic, and her two daughters are junior doctors.



Ms Helen Fernandes
Women in Surgery

Ms Fernandes is a consultant neurosurgeon (lead paediatric neurosurgeon) at Addenbrooke's Hospital, the first female surgeon to be appointed there. She specialises in the treatment of adult and paediatric patients with brain and spinal problems. She graduated from Newcastle University, gained her doctorate in 2000 and was awarded the Louis Alexander Research Fellowship and the Hunterian Professorship from the Royal College of Surgeons. Prior to her Cambridge appointment she was a Medical Research Council senior lecturer and honorary consultant neurosurgeon. Helen is a member of the British Association of Spinal Surgeons, British Cervical Spine Society and the East Anglian Spinal Society. She is Associate Director of Postgraduate Medical Education at Addenbrooke's and Chair of the national body Women in Surgery.



Professor Steve Field
Chair, Royal College of General Practitioners

Professor Field took up the position of RCGP Chair in November 2007 and led the college through Lord Darzi's review of the NHS, successfully promoting the RCGP's 'federated' model of patient care – with general practices working together to provide more services for patients in their local communities – as a workable alternative to polyclinics, and repositioning general practice at the heart of the NHS. Professor Field is recognised as a national leader in medical education. As Chair of the RCGP Education Network, he led the college's radical review of GP training, which led to the introduction of the first ever training curriculum for GPs in August 2007.

A practising GP in inner city Birmingham, Professor Field is Honorary Professor of Medical Education, University of Warwick, and Honorary Professor in the School of Medicine, University of Birmingham.

He has published many academic papers, reports and books – including a bestselling publication on the GP curriculum – and has presented papers at academic meetings around the world. He is a member of the faculty of the Harvard Macy Institute's programme for leading innovation in healthcare and education.

He is co-author of the landmark RCGP document *The Future Direction of General Practice: A roadmap*, and its follow-up, published in June 2008, *Primary Care Federations: Putting patients first*.



Dr Patricia Hamilton
Director of Medical Education, Department of Health

Besides being Director of Medical Education at the Department of Health, Dr Hamilton co-chairs the Modernising Medical Careers England Programme Board. She is responsible for overseeing the development and delivery of many of the medical educational projects referred to in *A High Quality Workforce*, and works closely with the newly formed Medical Education England.

She is working at the Department of Health on secondment from her post of consultant and senior lecturer in neonatal paediatrics at St George's, University of London. She was previously a medical director at St George's.

Until recently, she was President of the Royal College of Paediatrics and Child Health, having previously been Vice President for Training and Assessment. She has chaired many college committees and working parties, including those developing the paediatric curriculum and programmes. She was involved in developments in workplace-based assessments. She was responsible for producing training packages in child protection and child mental health.

As President of the RCPCH she was a member of the Academy of Medical Royal Colleges and sat on several of its education and training committees. She was Chair of the steering group of the Medical Leadership Competency Framework project completed by the Academy of Medical Royal Colleges and the National Institute for Innovation and Improvement. She is a board member of the Postgraduate Medical Education and Training Board, was co-Chair of the London Children's Clinical Pathways group and was a member of the leadership group of Lord Darzi's Next Stage Review of the NHS.



Professor Jacky Hayden
Postgraduate Medical Dean, North Western Deanery

Professor Jacky Hayden has been Dean of Postgraduate Medical Studies for Manchester University and the North Western Deanery since 1997; prior to this she was the Director of Postgraduate General Practice Education. She is the Chair of the English Deans Committee and Vice Chair of the Conference of Postgraduate Medical Deans, where she leads on the quality agenda, and she is lead dean for psychiatry and dermatology. She has been a member of the Medical Programme Board since January 2008 and is a member of Medical Education England. Her clinical background is general practice, and she is a member of the Council of the Royal College of General Practitioners, a PMETB partner and an associate for the GMC as part of its quality assurance team. She is an accredited mediator. She has established a range of innovative activities across the North Western Deanery, including a leadership programme for young GPs that started over 20 years ago, and an integrated medical leadership training programme for doctors in training. She is married to a consultant physician and has two sons.



Dr Anita Holdcroft
Women in Academic Medicine, British Medical Association
Reader in Anaesthesia and Honorary Consultant Anaesthetist, Imperial College London and Chelsea and Westminster Hospital

Dr Anita Holdcroft, Emeritus Professor of Anaesthesia at Imperial College London, is a clinician specialising in acute pain medicine, especially in females. She was the Secretary, then co-Chair, of the International Association for the Study of Pain Special Interest Group on Sex, Gender and Pain to 2005. She is Past President of the Forum on Maternity and the Newborn and President of the Section of Anaesthesia at the Royal Society of Medicine.

Her laboratory and clinical pain research has attracted Medical Research Council and charitable grants as well as funded studentships and keynote international lectures. As author and editor she has written books such as *Principles and Practice of Obstetric Anaesthesia and Analgesia*, *Core Topics in Pain* and *Crises in Childbirth*. Other publications include chapters on sex and gender differences in pain in Wall and Melzack's *Textbook of Pain* and papers on gender medicine, particularly relating to women and childbirth.

As a spin off from her research she champions academic women's employment issues and led the Women in Academic Medicine project funded by the Higher Education Funding Council for England, the BMA and the Medical Women's Federation (MWF). She has co-chaired the BMA Medical Academic Staff Committee and is the MWF Treasurer. She is married with four daughters.



Professor Sheila Hollins
Immediate Past President, Royal College of Psychiatrists

Professor Hollins was President of the Royal College of Psychiatrists from 2005 to 2008. She is married with four children and two grandchildren, and her eldest daughter is a consultant psychiatrist. She has an ongoing role as a carer in providing support to two of her children who have long-term conditions, and the experience of her son's learning disability strongly influenced her career direction. She trained part time in psychiatry, sharing childcare with her husband, a succession of au pairs and a hospital crèche.

She was in general practice before psychiatry, which influenced her family-based approach and her interest in co-morbid physical and mental health problems. She pioneered the involvement of people with learning disabilities as co-researchers and co-teachers in the medical school, and the dissemination through pictures of best practice to her patients and their carers. She has been Professor of Psychiatry of Learning Disability at St George's, University of London since 1991. Until she retired from clinical practice in 2006, she had been a consultant psychiatrist in south-west London for 25 years. She is currently chairing a steering group to develop a Europe-wide declaration and action plan on behalf of WHO Europe about the health and social care of children with intellectual disabilities; and she is planning to set up a spin-out company to further develop Books Beyond Words, her picture-based technology, to improve communication about health and other topics with people with learning disabilities.



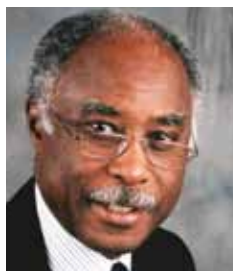
Miss Cathy Lennox
Consultant in orthopaedics and trauma surgery

Miss Lennox's specialty was traditionally a male specialty but now has increasing numbers of women coming through the ranks. Apart from an initial problem, back in the early 1970s when admission policy to medical school limited the number of women to 10%, she has encountered no major obstructions to her career. A surgical career in those days required training in general surgery as a pre-fellowship registrar to obtain the fellowship exam (FRCS) and then to go into higher specialty training. This involved fierce competition for a place on the much coveted orthopaedic training rotation. When she started a family she was able to take advantage of the newly created part-time training scheme, which made it possible to continue her work. Subsequently, as senior registrar, she did a job share for two years, by joining forces with another of the very few women in orthopaedic training. After this she became a full-time consultant. During her consultant years she has been involved in teaching, advising and mentoring trainees, both male and female. Her strong message has always been that, with appropriate enthusiasm and dedication, doctors can achieve an extremely rewarding career in whichever specialty they choose, regardless of gender.



Dr Katie Petty-Saphon
Medical Schools Council

Dr Petty-Saphon is the Executive Director of the Medical and of the Dental Schools Councils and of the Association of UK University Hospitals. She is a Director of the UK Clinical Aptitude Test Consortium and sits on the Board for Academic Medicine in Scotland. Prior to 2003 she had a career in the private sector, founding three successful companies. She read natural sciences at Cambridge and has a PhD in biochemistry from the University of Birmingham. She is a former Governor of the University of Hertfordshire and of primary and secondary schools in Saffron Walden. She is a former Vice Chair of Princess Alexandra Hospital NHS Trust, having been a non-executive director there for 10 years. She is a trustee of the Royal Medical Benevolent Fund and an associate fellow of Newnham College Cambridge, and in 2007 was the Chief Operating Officer for Sir John Tooke's independent inquiry into Modernising Medical Careers. She is married with two children – and 10,000 trees that she planted in 2000. Apart from two sets of three months' maternity leave she has always worked full time – and so has much experience of juggling and multi-tasking.



Mr Bernard Ribeiro
Former President of the Royal College of Surgeons of England

Mr Ribeiro qualified at Middlesex Hospital Medical School and was awarded the fellowship in 1972. In 1979 he was appointed as a consultant general surgeon to Basildon Hospital, Essex, with a special interest in laparoscopic and gastrointestinal surgery. He introduced therapeutic laparoscopic surgery to the trust in 1991 with the aim of establishing an advanced laparoscopic training unit.

He has been a senior examiner in surgery for the University of London and the University of Oxford and a member of the Court of Examiners of the Royal College of Surgeons. He is currently an examiner for the new medical school in Brighton. He was Honorary Secretary and President of the Association of Surgeons of Great Britain and Ireland (1991–2000), represented the Association of Surgeons on the Senate of Surgery and was Chair of the Distinction Awards Committee of the association (2000–04). He was elected to the Council of the Royal College of Surgeons of England in 1998.

He received a CBE for services to medicine in January 2004 and has been made an honorary fellow of several Royal Colleges and academies. He was President of the Royal College of Surgeons of England from 2005 to 2008 and was appointed Knight Bachelor in December 2008.



Dr Joan La Rovere
Director of the Paediatric Cardiac Intensive Care Unit and Consultant Paediatric Intensivist at the Royal Brompton Hospital, London, and Honorary Senior Lecturer at Imperial College London

Joan La Rovere is Director of the Paediatric Intensive Care Unit and consultant intensivist at the Royal Brompton Hospital, where she has been a consultant since 1999, and is an honorary senior lecturer at Imperial College.

Raised in Boston, Massachusetts and educated at Phillips Academy Andover, she graduated from Harvard University in 1988, followed by an MSc in genetics at St Andrew's University, before completing her medical training at Columbia University College of Physicians and Surgeons in New York, graduating in 1993. Paediatric residency at Children's Hospital Boston was followed by a move in 1996 to Great Ormond Street Hospital in London as a fellow in paediatric intensive care, and appointment as a consultant at the Royal Brompton Hospital in 1999.

Her medical research focuses on outcomes following cardiac surgery and she has been instrumental in developing lesion-specific care pathways for children of all ages undergoing cardiac surgery, and the use of databases to detail clinical outcomes. She sits on the International Multi-Societal Database Committee for Pediatric and Congenital Heart Disease. In addition to her clinical and managerial role, Dr La Rovere is the Royal College of Paediatrics and Child Health's tutor at the Royal Brompton Hospital and is a member of the Chief Medical Officer for England's Expert Working Group on Revalidation and Medical Education. She has organised and spoken at numerous medical conferences, both nationally and internationally.

Dr La Rovere was elected a member of the Windsor Leadership Trust, an organisation that brings together top leaders from every sector to reflect on how they use their influence, decisions and actions to benefit their organisations and wider society. Deeply involved in issues of healthcare leadership and education, Dr La Rovere also works to educate the next wave of healthcare professionals by developing medical curricula, innovating learning programmes and training professionals. She helps to conceptualise and employ the most cutting-edge technology, including the use of virtual education. A keen advocate of medical education, Dr La Rovere is a trustee of IMET (International Medical Education Trust) 2000, a charity aimed at promoting links and cooperation between the western and developing world, including the development of virtual medical education. She also sits on the Admissions Committee of Imperial College Medical School, as well as teaching Imperial College medical students.

Dr La Rovere is co-founder and Vice-President of Virtue Foundation, a public charitable and non-governmental organisation with special consultative status to the United Nations. The Foundation's mission is to increase awareness of prevalent global issues, to inspire people to action and to render humanitarian assistance through healthcare, education, and empowerment initiatives. Virtue Foundation undertakes healthcare, education and empowerment initiatives for women and children in the developing world.

She is married with one child.



Professor Bhupinder Sandhu

Chair of the British Medical Association's Equal Opportunities Committee and former Chair of the Medical Women's Federation

Bhupinder Sandhu is Consultant Paediatrician and Gastroenterologist at the Bristol Royal Hospital for Children and an honorary professor at the University of Bristol and the University of the West of England (UWE). She is currently President of the Commonwealth Association of Paediatric Gastroenterology and Nutrition.

In 2002 she received an Asian Women of Achievement Award from Cherie Blair. She is being honoured with a Doctor of Science degree by UWE for her 'outstanding contribution to public services and exemplary role model for women in science and medicine'.

Coming from India at the age of 12 in 1963 with little English, she gained a place at University College London and graduated in 1974. After paediatric appointments at University College, King's College Westminster and Great Ormond Street hospitals and a research fellowship, she obtained a doctorate from the University of London. She was appointed to the University of Bristol in 1988 and subsequently developed the Paediatric Gastroenterology Department there. She is a founder member of the British Society of Paediatric Gastroenterology and Nutrition, hosted its inaugural meeting, served as its secretary and convener, and recently led on producing national guidelines on the management of inflammatory bowel disease in children. She has held many committee and board-level posts in Bristol, and nationally and internationally. She has served as an external examiner for universities in the UK and abroad. She spearheaded the Royal College of Paediatrics and Child Health/VSO Fellowship Scheme (described by Lord Crisp as a beacon of excellent practice) and chaired a European research working group. She has published extensively, with book chapters and over 80 papers, and has chaired and spoken at many international meetings, including working with and advising the World Health Organization.

Her public service roles have included being a foundation board member of the Food Standards Agency, board member and trustee of VSO, Deputy Chair of the Board of Governors of UWE, Chair of the BBC West Regional Advisory Council and a chair of school governors. She currently serves on the governing Council of Bristol Old Vic Theatre School. She is married with two daughters, both following careers in medicine.



Professor Deborah Sharp
**Medical Schools Council and Chair of the Council of Heads of Medical Schools’
Committee on Women in Clinical Academia**

Professor Sharp is Professor of Primary Health Care and Head of the Academic Unit of Primary Health Care at the University of Bristol. She was previously lecturer and then senior lecturer at the United Medical and Dental Schools of Guy’s and St Thomas’ in the Department of General Practice and Honorary Senior Lecturer at the Institute of Psychiatry. She obtained one of the first Mental Health Foundation GP Research Training Fellowships, through which she undertook the work for her PhD on postnatal depression in a community sample in south London. She took up the foundation Chair in primary health care in 1994, the first woman to be appointed to a substantive chair in Bristol, and has built up a world-class department over the last 15 years. The unit has a very strong research programme, with 70% of its submission rated 3* or 4* in the 2008 Research Assessment Exercise. They are founder members of the NIHR School for Primary Care Research.

Professor Sharp is immediate Past Chair of the Society for Academic Primary Care, represents primary care at the Medical Schools Council, and sat on the GMC Education Committee and on the Walport Academic Careers Panel. Between 2000 and 2003 she was Head of School in the Faculty of Medicine at Bristol, and it was during this time that she became aware of the particular recruitment and retention issues for women in academic medicine. She is an active member of the Medical Women’s Federation. In 2006 she chaired the Council of Heads of Medical Schools’ Women in Academic Medicine Working Party, and has continued both locally and nationally to be involved in the career possibilities in academic medicine for women at all levels.



Dr Sheila Shribman
National Clinical Director for Children, Young People and Maternity Services

Appointed National Clinical Director for Children, Young People and Maternity at the Department of Health in December 2005, after 22 years as a consultant paediatrician with diverse experience in children’s health services, Dr Shribman has held posts in NHS management, as a medical director for 11 years and as a chief executive. She has been a senior officer of the Royal College of Paediatrics and Child Health and held posts in continuing professional development, workforce planning, child protection and policy areas. Her current clinical interest is in neurodisability. She is married to a GP and has three young adult children.



Miss Susan Ward
Medical Women's Federation

Sue Ward was elected Vice-President of the Medical Women's Federation at the spring meeting in 2005. Her current post is as consultant in obstetrics and gynaecology for Sherwood Forest Hospitals NHS Foundation Trust. She also holds the post of Associate Postgraduate Dean at the University of Nottingham, with responsibility for arranging the Foundation Programme in the Trent region.

A graduate of the University of Nottingham, Miss Ward decided to pursue a career in obstetrics and gynaecology. In order to broaden her experience, she spent a period as an anatomy demonstrator and then undertook a surgical SHO rotation during which time she obtained her FRCS (Edinburgh). She then moved into obstetrics and gynaecology, obtaining her MRCOG and an MD. She is the college tutor for the RCOG at King's Mill. She is an enthusiastic teacher of postgraduates, undergraduates and paramedical staff both in formal educational settings and on a one-to-one basis in the operating theatre and clinic.

Despite working full time as an NHS consultant and with all her teaching responsibilities, she has found the time to build and decorate a new house together with her husband. She has been widowed and remarried and has two children, one from each marriage, as well as two cats. One of the most important experiences in her career was a student elective spent in Africa, and this experience has influenced her future plans, which are to 'leave a cohort of well-trained doctors behind her, work in Africa and then retire disgracefully'.



Dr Jane Youde
Consultant Geriatrician

Dr Jane Youde is a consultant geriatrician at Derby Hospitals NHS Foundation Trust. She is the Lead Clinician for Medicine for the Elderly in Derby and has a special interest in falls and syncope. Dr Youde is actively involved in the British Geriatric Society and holds the posts of Secretary of the Falls Section of the British Geriatric Society and Secretary for the Trent British Geriatric Society.

Annex 5: Evidence collected

The National Working Group on Women in Medicine met six times between October 2008 and March 2009. It received oral evidence from 15 stakeholders including:

Lucy Warner – Department of Health Revalidation Support Team

Dr Lucy-Jane Davis – BMA Junior Doctors Committee

Najette Ayadi O'Donnell – BMA Medical Students Committee

Professor Chris McManus – Professor of Psychology and Medical Education, University College London

Julie Cornish – Association of Surgeons in Training

Cathy Williams – PMETB

Dr Sue Shepherd and Professor Jane Dacre – RCP

John James – Department of Health Workforce Leadership Programme

Dr Sarah Thomas – Postgraduate Dean Lead for Flexible Training

Professor Jonathan Montgomery – ACCEA

Dr Clare Gerada – RCGP and Practitioners Health Programme

Elizabeth Kelan – Centre for Women in Business, London Business School

Mike Farrar – North West Strategic Health Authority

Ailsa Donnelly – Patient Partnership Group, RCGP

Dr Sheila Shribman – National Clinical Director for Children, Young People and Maternity

Additionally, the Chair received numerous representations from individual female doctors and met with groups of doctors from the Oxford Radcliffe Hospitals and the Royal Brompton Hospital.

A subcommittee, chaired by Dr Sheila Shribman, was established to examine the issue of childcare in more detail. It met twice, in December 2008 and January 2009. NHS Employers, HM Treasury and the Department for Children, Schools and Families were represented, as well as a junior doctor and mother from the West Midlands, in addition to Dr La Rovere and Professor Hayden from the main working group.

Glossary

ACCEA	Advisory Committee for Clinical Excellence Awards
BMA	British Medical Association
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
DCSF	Department for Children, Schools and Families
GMC	General Medical Council
GP	general practitioner
IMG	international medical graduate
MWF	Medical Women's Federation
NHS	National Health Service
NHS MEE	National Health Service Medical Education England
PMETB	Postgraduate Medical Education and Training Board
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
SAS	staff or specialist grade
SHA	strategic health authority
ST1	specialty training year 1
WHO	World Health Organization

References

- 1 Higher Education Funding Council for England.
- 2 Higher Education Funding Council for England.
- 3 Royal College of Physicians. *Women and medicine: The future*. London: RCP; June 2009.
- 4 The Law Society. *Earnings and work of private practice solicitors in 2007*. London: The Law Society; February 2008.
- 5 The Law Society. *Women solicitors 2004: Research findings*. London: The Law Society; 2004.
- 6 Wylie C. *Trends in feminization of the teaching profession in OECD countries 1980–95*. Geneva: International Labour Office; March 2000.
- 7 Notzer N, Brown S. The feminization of the medical profession in Israel. *Medical Education* 1995; 29(5): 377–81.
- 8 Review May 2004 – April 2008, UK Resource Centre for Women in Science, Engineering and Technology.
- 9 Department for Trade and Industry. *Maximising Returns to Science, Engineering and Technology Careers*. London: DTI; 2002.
- 10 Women into Science, Engineering and Construction. www.wisecampaign.org.uk.
- 11 Office for National Statistics. *Birth statistics (FM1 No. 36)*. Table 1.7b. London: ONS; 2008.
- 12 Royal College of Physicians. *Women and medicine: The future*. London: RCP; June 2009.
- 13 Lambert TW, Evans J, Goldacre MJ. Recruitment of UK-trained doctors into general practice: findings from national cohort studies. *Br J Gen Pract* 2002; 52(478): 364–7, 369–72.
- 14 Levitt C, Candib L, Lent B, Howard M. *Women Physicians and Family Medicine Monograph/Literature Review*. www.womenandfamilymedicine.com/files/pdf-documents/wwwpwfm_monograph_01-08-2008.pdf.
- 15 Royal College of Physicians. *Women and medicine: The future*. London: RCP; June 2009.
- 16 Levitt C, Candib L, Lent B, Howard M. *Women Physicians and Family Medicine Monograph/Literature Review*. www.womenandfamilymedicine.com/files/pdf-documents/wwwpwfm_monograph_01-08-2008.pdf.
- 17 Allen I. Women doctors and their careers: what now? *BMJ* 2005; 331: 569–72.
- 18 McManus IC, Sproston KA. Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice, or cohort effect? *J Epidemiol Community Health* 2000; 54: 10–16.
- 19 Darzi A. *High Quality Care for All: NHS next stage review*. London: Department of Health; 2008.

- 20 National Institute for Health Research. NIHR Integrated Academic Training. www.nihrtcc.nhs.uk/intetacatrain.
- 21 Medical Schools Council. *Women in Clinical Academia: Attracting and Developing the Medical and Dental Workforce of the Future*. London: Medical Schools Council; 2007.
- 22 Mayer AP, Files JA, Ko MG, Blair JE. Academic advancement of women in medicine: do socialized gender differences have a role in mentoring? *Mayo Clin Proc* 2008; 83(2): 204–7.
- 23 Foster SW, McMurray JE, Linzer M, Leavitt JW, Rosenberg M, Carnes M. Results of a gender-climate and work-environment survey at a Midwestern academic health center. *Acad Med* 2000; 75(6): 653–60.
- 24 Montgomery J, Chair, Advisory Committee on Clinical Excellence Awards. Briefing for National Working Group on Women in Medicine, 8 January 2009.
- 25 Grunebaum A, Minkoff H, Blake D. Pregnancy among obstetricians: a comparison of births before, during and after residency. *Am J Obstet Gynecol* 1987; 157(1): 79–83.
- 26 Tesch BJ, Osborne J, Simpson DE, Murray SF, Spiro J. Women physicians in dual-physician relationships compared with those in other dual-career relationships. *Acad Med* 1992; 67(8): 542–4.
- 27 General Medical Council. *Good Medical Practice*. London: GMC; 2006.
- 28 Postgraduate Medical Education and Training Board. PMETB surveys reveal trainee doctors' satisfaction on the increase but demand for flexible training is unmet. PMETB press release, 25 July 2008.
- 29 Gray SF, Goodyear HM, Jones MJT. Outcomes of flexible training compared to full time training during the Specialist Registrar Grade in the UK. *Med Educ Online* 2005. www.med-ed-online.org/pdf/10000007.pdf.
- 30 Brigham and Women's Hospital Office for Women's Careers. www.brighamandwomens.org/cfdd/owc/.
- 31 Nadelson C. A Model for Women's Career Development: An Office for Women's Careers. Presentation at Griffith University, Queensland, August 2006.

Photo credits:

Getty Images

Wellcome Library

Anne-Katrin Purkiss/Wellcome Library (Professor Dame Julia Polak, page 45)

Jeff Stultiens (Dame Margaret Turner-Warwick, page 51)



© Crown copyright 2009
298315 1p 750 October 09 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title visit
www.orderline.dh.gov.uk and quote:
298315/*Women doctors: making a difference*

Tel: 0300 123 1002
Minicom: 0300 123 1003
(8am to 6pm, Monday to Friday)
www.dh.gov.uk/publications



50% recycled

This is printed on
50% recycled paper