



IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on Women in Medicine

September 2017

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ORGANISATION
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Mission Statement

The role of the IMO is to **represent** doctors in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring, **efficient** and effective Health Service.



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INTRODUCTION

Irish medicine has never been so diverse in terms of gender. Currently 41% of doctors in Ireland are female, while 53% of doctors in Ireland between the ages of twenty-five and thirty-four are female. This represents a sea change in gender diversity from that which existed just over 100 years ago. Between the years 1897 and 1906, it is estimated that just forty women matriculated in medicine at Irish universities, compared with some 2,482 men.¹ By comparison, last year alone 379, or 52% of medical interns entering the public health system, were female,² while 55% of all medical students are female.³

Though there has unquestionably been huge progress, international and national research suggests that many doctors still face gender-based discrimination in the workplace which hampers career prospects and advancement, and threatens mental well-being. In late 2016 the Irish Medical Organisation conducted a large-scale survey of its members which asked respondents to provide their insights into the various gender issues within Irish medicine. Chief amongst these responses were a number of key themes: (i) gender-based bullying, gender-based harassment, and sexual harassment are common in Irish healthcare and exercise a disruptive and harmful influence on doctors' working lives; (ii) gender continues to play a role in specialty choice, leading to an inequality of gender representation in certain specialties; and (iii) doctors in Ireland exhibit some difficulty in adequately striking a strong balance between the work and family commitments, in part due to an absence of workplace supports.

It is the aim of this paper to highlight the gender-related issues that continue to affect medical practitioners in Ireland, and to encourage policy makers and health services management to effectively address these issues, building a health service where employment practices strive to provide equality of opportunity.

GENDER-BASED BULLYING, GENDER-BASED HARASSMENT, AND SEXUAL HARASSMENT

Gender-based bullying, gender-based harassment, and sexual harassment are common features of medical practice in Ireland.

Gender-based bullying is defined as repeated inappropriate behaviour related to gender, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could reasonably be regarded as undermining the individual's right to dignity at work.

Gender-based harassment is unwanted conduct related to gender, which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person.

Sexual harassment is similar to gender-based harassment but refers specifically to unwanted verbal, non-verbal or physical conduct of a sexual nature.

1 L. Kelly, *Irish Medical Women c.1880s-1920s: the origins, education and careers of early women medical graduates from Irish institutions*, National University of Ireland, Galway, 2010, pp. 77-78.

2 Health Service Executive, *Sixth Annual Assessment of NCHD Posts: 2015-2016*, National Doctors Training and Planning, Dublin, 2016, p. 3.

3 Higher Education Authority, 2016, personal correspondence.

Table 1 – Rates of Gender-Based Bullying, Gender-Based Harassment, and Sexual Harassment Experienced by Various Categories of Doctors during the Past Two Years

Category of doctor	% who experienced gender-based bullying in the last two years	% who experienced gender-based harassment in the last two years	% who experienced sexual harassment in the last two years
Total NCHDs	20.7%	26.2%	18.3%
Male NCHDs	5.8%	15.4%	11.5%
Female NCHDs	27.7%	31.3%	21.4%
Total Consultants	10.1%	8.7%	1.5%
Male Consultants	6.5%	3.2%	3.2%
Female Consultants	13.2%	13.2%	0%
Total GPs	5.4%	7.2%	3.0%
Male GPs	1.1%	1.1%	1.1%
Female GPs	10.4%	14.3%	5.2%
Total Community and Public Health	4.4%	8.7%	0%
Male Community and Public Health	0%	0%	0%
Female Community and Public Health	5.0%	10.0%	0%

Research conducted by the Irish Medical Organisation shows that 20.7% of NCHDs, 10.1% of consultants, 5.4% of GPs, and 4.4% of community health and public health doctors surveyed report being bullied on the basis of their gender. Female doctors report such gender-based bullying at a far higher rate, as Table 1 demonstrates. In particular, female NCHDs appear to experience these workplace problems most commonly. The reasons for the higher prevalence of reported bullying amongst female doctors is likely complex. In it they may be explained by an interaction between actual higher prevalence in experiences of bullying against women, coupled with a lower perception of opportunities for defence against this behaviour and less reluctance to classify undermining behaviour as bullying amongst women.⁴ More than one-in-four female NCHDs report they have been bullied on the basis of their gender during the past two years, whereas only one-in-seventeen male NCHDs identified themselves as experiencing such behaviour.

4 D. Salin, 'The Significance of Gender in the Prevalence, Forms and Perceptions of Workplace Bullying', *Nordiske Organisasjonsstudier*, Vol. 5, No. 3, 2003, pp. 30-50.

The psychological and health consequences of bullying to the victim are well established in research, and victimisation by such behaviour is associated with stress,⁵ depression,⁶ obesity,⁷ chronic illness,⁸ an increase absence from the workplace,⁹ and even cardiovascular disease.¹⁰

The IMO Survey on Gender Issues in Irish Medicine enquired as to the sources of gender based bullying. Here doctors were asked to list all sources of experienced gender-based bullying in the last two years. Amongst female NCHDs, the cohort of doctors who most commonly report being the victims of gender-based bullying, the reported sources of such bullying are diverse. Of these female NCHDs who state they are victims of gender-based bullying, 50% report being bullied by another doctor, 40% by an employer or member of management, 23% by a non-physician co-worker, and 33% by a patient. The sample of male NCHD victims of gender-based bullying was too small to draw a robust comparison between the sources of bullying, however the sample that was presented also suggested a diversity of sources.

Of those female NCHDs who report being victims of gender-based harassment during the past two years, 43% report being harassed by another doctor, 17% by an employer or member of management, 11% by a non-physician co-worker, and 48% by a patient. Reports of the sexual harassment of female NCHDs during the past two years follow a similar pattern in terms of their sources as 30% report being sexually harassed by another doctor, 13% by an employer or member of management, 9% by a non-physician co-worker, and 61% by a patient.

Addressing Bullying, Harassment, and Sexual Harassment: Recommendations

With the launch of the Respect Charter on the 6th of April 2017, the IMO, the HSE and the Forum of Irish Postgraduate Training Bodies are taking the lead on addressing poor behaviour within the medical profession. The Joint Working Group (JWG) established under the Respect Charter commit to taking all actions necessary to ensure a culture of respect and collaboration in medical practice and education.

The outcomes of the working group should:

1. Identify the extent of gender-based bullying, gender-based harassment and sexual harassment experienced by doctors.
2. Ensure that doctors in managerial roles, educational roles, as well as those in clinical and training roles understand and identify the nature and consequences gender based bullying, gender-based harassment and sexual harassment.
3. Ensure that appropriate policies and procedures are in place to address all forms of bullying and harassment and that barriers to reporting are removed.

The diversity of the reported sources of gender-based bullying, gender-based harassment, and sexual harassment indicate that a multi-faceted approach is required to address these inappropriate behaviours. Actions identified by the working group, where possible, should be extended to hospital management and other healthcare professionals. Educational campaigns should also ensure that patients are aware of what constitutes gender-based bullying, gender-based harassment, and sexual harassment.

5 M.A-L. Vartia, 'Consequences of workplace bullying with respect to the well-being of its targets and the observers of bullying', *Scandinavian Journal of Work, Environment, and Health*, Vol. 27, No. 1, 2001, pp. 63-69;

6 Ibid.

7 M. Kivimäki et al., 'Workplace bullying and sickness absence in hospital staff', *Occupational and Environmental Medicine*, Vol. 57, 2000, pp. 656-660.

8 Ibid.

9 Ibid.

10 M. Kivimäki et al., 'Workplace bullying and the risk of cardiovascular disease and depression', *Occupational and Environmental Medicine*, Vol. 60, 2003, pp. 779-783.

GENDER IN ISSUES IN SPECIALTY CHOICE AND CAREER PROGRESSION

Figures from the Medical Council's Medical Workforce Intelligence Report show that, while approximately 41% of all doctors practising within the state are female,¹¹ 39% of consultants within the public health service are female,¹² and 42% of general practitioners are female.¹³ This represents a small but significant preference for general practice amongst female medical practitioners, the reasons for which have not been comprehensively explored in Ireland. This preference is highly pronounced at higher specialist trainee level, as currently 68% of all those in general practice training programmes are female.¹⁴ While broadly 39% of hospital consultants are female, serious discrepancies between the ratios of male to female consultants, extent to particular medical specialities, as illustrated in the table below.

Table 2 - Proportion of Specialists Registered with Medical Council Who Are Female

Area of Practice	% of Specialists Who Are Female
Anaesthesia	31.7%
Cardiology	12.0%
Cardiothoracic Surgery	14.3%
Chemical Pathology	18.2%
Child and Adolescent Psychiatry	66.4%
Clinical Genetics	50.0%
Clinical Neurophysiology	25.0%
Clinical Pharmacology and Therapeutics	50.0%
Dermatology	63.1%
Emergency Medicine	20.0%
Endocrinology and Diabetes Mellitus	29.5%
Gastroenterology	27.7%
General (Internal) Medicine	28.6%
General Practice	50.5%
General Surgery	9.1%
Genito-Urinary Medicine	66.7%
Geriatric Medicine	42.9%
Haematology	50.0%
Haematology (Clinical and Laboratory)	43.8%
Histopathology	45.0%
Immunology (Clinical and Laboratory)	30.0%
Infectious Diseases	58.1%

11 Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 58

12 Health Service Executive, *Consultants by Specialty (HSE & S38 Agencies): December 2016*, 2016, p. 1

13 M. O'Kelly et al., *Structure of General Practice in Ireland 1982 – 2015*, Dublin, Irish College of General Practitioners, 2015, p. 17.

14 Health Service Executive, *Sixth Annual Assessment of NCHD Posts: 2015-2016, National Doctors Training and Planning*, Dublin, 2016, p. 14.

Area of Practice	% of Specialists Who Are Female
Medical Oncology	39.0%
Microbiology	61.2%
Nephrology	32.2%
Neurology	30.4%
Neuropathology	66.7%
Neurosurgery	7.7%
Obstetrics and Gynaecology	40.4%
Occupational Medicine	33.3%
Ophthalmic Surgery	26.9%
Ophthalmology	46.0%
Oral and Maxillo-Facial Surgery	6.7%
Otolaryngology	19.5%
Paediatric Cardiology	25.0%
Paediatric Surgery	11.1%
Paediatrics	47.0%
Palliative Medicine	64.6%
Pharmaceutical Medicine	27.3%
Plastic, Reconstructive, and Aesthetic Surgery	24.2%
Psychiatry	48.8%
Psychiatry of Learning Disability	69.7%
Psychiatry of Old Age	60.2%
Public Health Medicine	71.0%
Radiation Oncology	31.4%
Radiology	32.2%
Rehabilitation Medicine	53.3%
Respiratory Medicine	18.4%
Rheumatology	35.8%
Sports and Exercise Medicine	10.7%
Trauma and Orthopaedic Surgery	6.2%
Tropical Medicine	0.0%
Urology	8.8%

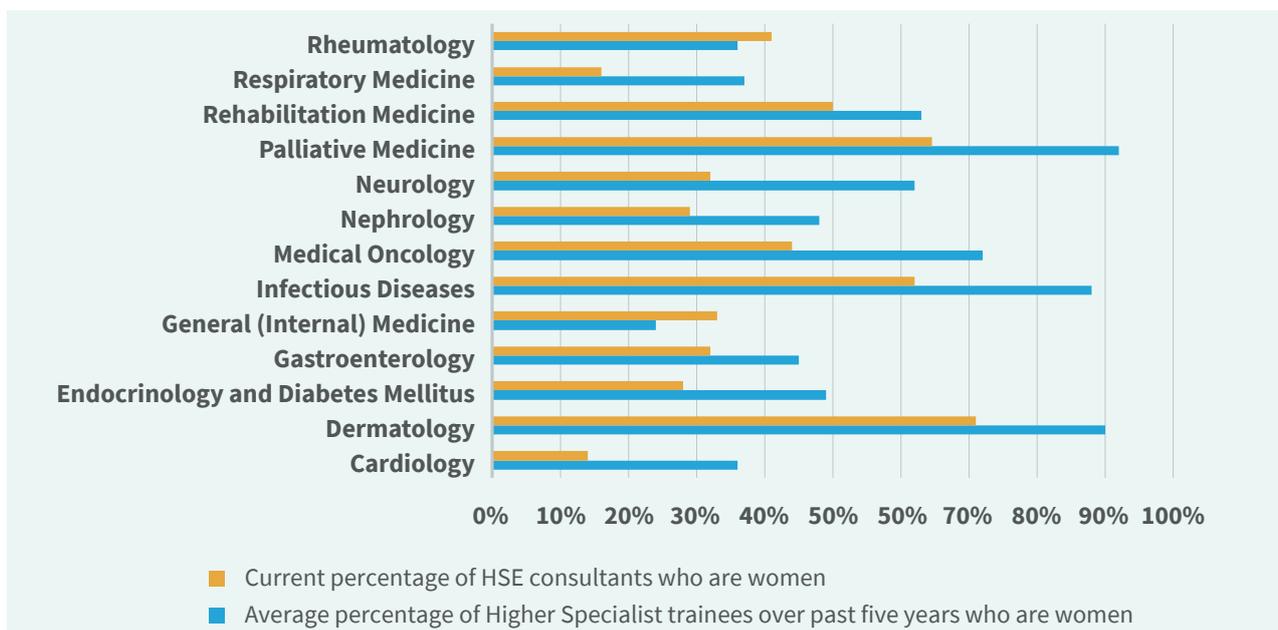
Source: Medical Council, *Medical Workforce Intelligence Report*, Dublin, 2016, p.60.

From this table it is clear that a number of areas of practice of consultant doctors do not suffer from female underrepresentation. Dermatology, geriatric medicine, medical oncology, obstetrics and gynaecology, paediatrics, pathology, psychiatry, and ophthalmology, are some of the areas of specialisation in which there is approximately equal gender representation or, in some areas, female dominance in terms of representation in consultant posts, relative to the percentage of female doctors in practice generally. Other areas, however, such as cardiology, endocrinology, nephrology, neurology, neurology, and most of the surgical specialties exhibit disproportionately high male representation.

International research¹⁵ shows that discrimination and sexual harassment influence specialty choice for both genders, however to a much greater extent amongst women; a perception that certain specialties are less compatible with family commitments acts as a barrier to women, including a lack of flexible or part-time training or working arrangements; and perceptions that women's skill set or abilities may not be compatible or suited to certain specialties. The academic literature also suggests that inconsistent focus on career advancement, family commitments, and a tendency to understate accomplishments further affects female attainment of leadership positions in medicine.¹⁶

A recent assessment of women working in hospital medicine in Ireland identified motherhood as "the common denominator to most of the difficulties encountered" by the study's female participants.¹⁷ Difficulties experienced by some participants included the time out they had taken from work for reasons related to motherhood becoming the focus of interviews and, as a result, some participants had attempted to limit the amount of time taken out of work or had delayed starting a family until they had attained an acceptable level of career security.¹⁸

Graph 1 - Percentages of Higher Specialist Trainees v. HSE Consultants (Female), Medical Specialties



Source: Health Service Executive, *Annual Assessments of NCHD Posts: 2011-2012 to 2015-2016, National Doctors Training and Planning, Dublin, 2012-2016*; Health Service Executive, *Consultants by Specialty (HSE & S38 Agencies): December 2016, 2016*.

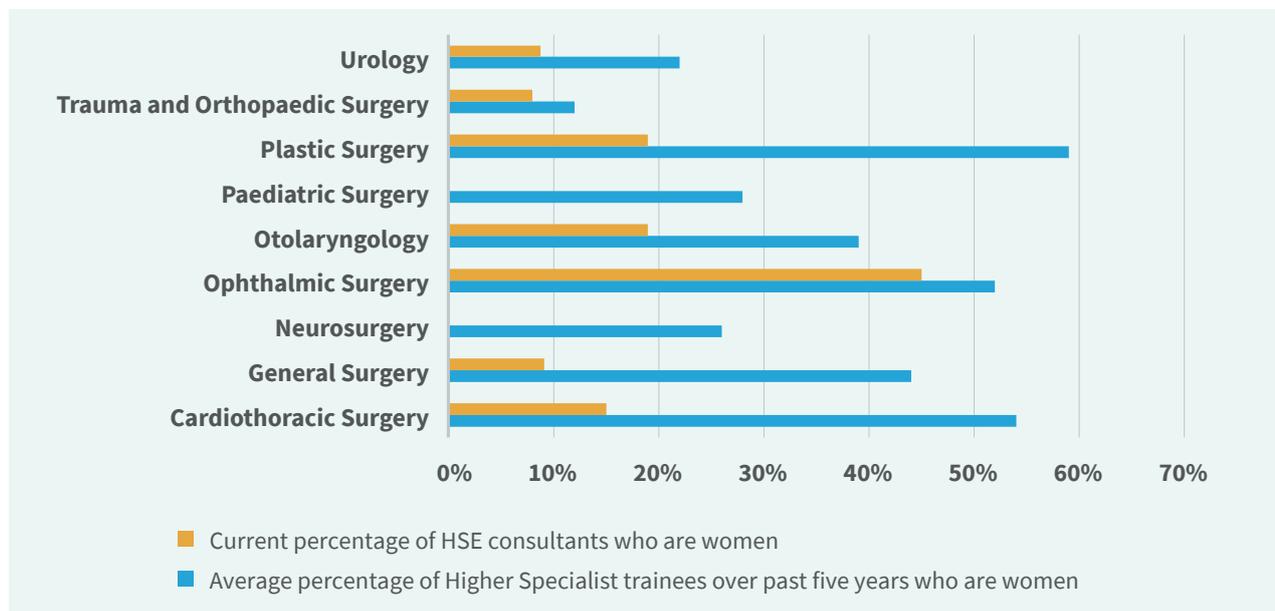
15 H.A. Sanfey et al., 'Influences on Medical Student Career Choice: Gender or Generation?', *JAMA Surgery*, Vol. 141, No. 11, November 2006, pp. 1086-1094. S. Redman et al., 'Determinants of career choices among women and men medical students and interns', *Medical Education*, Vol. 28, No. 5, September 1994, pp. 361-371. J. Park et al., 'Why are women deterred from general surgery training?', *The American Journal of Surgery*, Vol. 190, No. 1, July 2005, pp. 141-146. D.A. Gargiulo, N.H. Hyman, and J.C. Herbert, 'Women in Surgery: Do We Really Understand the Deterrents?', *JAMA Surgery*, Vol. 141, No. 4, April 2006, pp. 405-408.

16 C. Schueller-Weidekamm and A. Kautzky-Willer, 'Challenges of Work-Life Balance for Women Physicians/Mothers Working in Leadership Positions', *Gender Medicine*, Vol. 9, No. 4, Aug. 2012, pp. 244-250; E. Gjerberg, 'Women doctors in Norway: the challenging balance between career and family life', *Social Science & Medicine*, Vol. 57, No. 7, Oct. 2003, pp. 1327-1341; K.J. Kværner, O.G. Aasland, and G.S. Botten, 'Female medical leadership: cross sectional study', *BMJ*, Vol. 318, No. 7176, pp. 91-94.

17 K. Meghen, 'Women in Medicine: Facts, Figures and Personal Experiences', *Irish Medical Journal*, Vol. 106, No. 2, pp. 39-42.

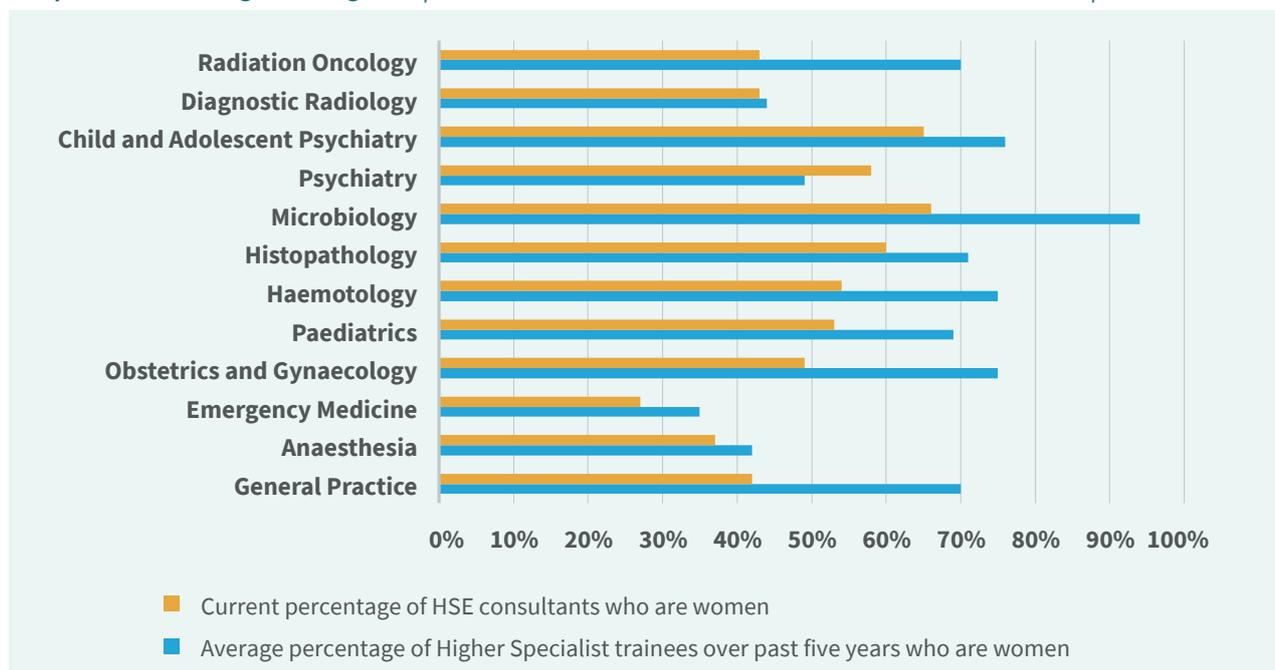
18 Ibid.

Graph 2 - Percentages of Higher Specialist Trainees v. HSE Consultants (Female), Surgical Specialties



Source: Health Service Executive, Annual Assessments of NCHD Posts: 2011-2012 to 2015-2016, National Doctors Training and Planning, Dublin, 2012-2016; Health Service Executive, Consultants by Specialty (HSE & S38 Agencies): December 2016, 2016.

Graph 3 - Percentages of Higher Specialist Trainees v. HSE Consultants (Female), Various Specialties



Source: Health Service Executive, Annual Assessments of NCHD Posts: 2011-2012 to 2015-2016, National Doctors Training and Planning, Dublin, 2012-2016; Health Service Executive, Consultants by Specialty (HSE & S38 Agencies): December 2016, 2016.

The above charts demonstrate an observable relationship between the number of female practitioners within the training pipeline and the number of consultants practising within the corresponding specialty. Such a correlation is less observable however within certain specialties, particularly cardiology, endocrinology, nephrology, neurology, neurology, and the surgical specialties, with the exception of ophthalmic surgery.

As is clear from the above graphs, this issue is most acute within the surgical specialities, with surgery remaining the least popular specialty choice for female medical practitioners. A recent study on the role of gender in Irish medicine, found that its respondents perceived surgery to be “a male-oriented and dominated specialty and that being female [is] detrimental to career progression”.¹⁹ Surgery was the only specialty group identified within this study where respondents felt that their gender had career implications, and posited that it may be that the choice of surgery is relatively low amongst female practitioners “due to a perfect storm of perceived gender bias and an unattractive lifestyle, which impacts negatively on its choice”.²⁰

Respondents to the IMO’s survey, when questioned on the factors they took into consideration when making their specialty choice, exhibited some clear gender distinctions. While a personal interest in the specialty was the most frequently cited consideration for both male and female NCHDs (59% to 56% respectively), female NCHDs were far more likely to mention work-life balance and job flexibility (33%) as a relevant consideration than their male counterparts (19%).

Indeed, when questioned on what factors may impede the advancement of female medical practitioners, many female respondents to the IMO’s survey cited poor work life balance as a concern, with one observing that

“[f]emale doctors [are] opting out of specialties that do not allow enough time for raising a family. Females feel they have to choose either family or career goals in specialties like surgery.” These sentiments were echoed by other female respondents who felt that *“[w]omen want to have families and the consultancies and the training especially for example for surgery are just physically impossible”*.

However others felt that something of a “boy’s club” exists within particular areas of Irish medicine, which can, at times, manifest in discriminatory practices. One female respondent reported that:

“I have been asked directly when I plan on having children: at a pre SPR visit to a hospital I was asked by the head why should he give me the job ahead of a man who wouldn’t be taking maternity leave at any stage on the training scheme.”

One female consultant respondent observed that

“until well after 2000, there were only a small number of female [surgical] trainees, and there was a significant fall off rate of female trainees during the training process - due to the length of time taken in training and the onerous on call demands, which would preclude such a trainee considering starting a family.” She went on to note, however, that *“[o]ver the past 10 years more female trainees have been appointed and this will translate to more consultants in [surgery] in due course”*.

While there have been some recent increases in the number of women entering surgical training programmes, there has been little variation within the numbers of female trainees in such programmes over the past five years, with no indication that the numbers of women entering surgical training are growing at present. Reducing barriers to entry for female medical practitioners to the surgical specialties may lead to a more even spread of female representation across specialty training programmes, with the consequences of improving male representation in training programmes in which there currently exists a low number of male trainees.

19 S. McAleese, *The “humanisation” of medicine? : the feminisation of medicine: a qualitative study of the career experiences of female doctors and implications for human resources management in Ireland*, [PhD Thesis], Dublin, Royal College of Surgeons in Ireland, 2013, p. 157.

20 Ibid.

Addressing Gender Issues in Specialty Choice and Career Progression

While the number of male and female general practitioners and hospital doctors is broadly representative of the gender ratio evident amongst the body of practising doctors, gender disparities continue to exist within certain specialities. Gender-based barriers to specialty choice and progression should be addressed through the following:

- A comprehensive analysis should be conducted by the HSE of the reasons underlying the gender disparities within individual medical specialities, both at senior practitioner and trainee levels. This review should encompass an assessment of work-life balance within all medical specialties, and the role it may have in specialty choice.
- Recruitment efforts should be made to encourage equal gender representation within all medical specialties, targeting in particular those specialties in which the underrepresentation of one gender is clearly evident.
- Training on discriminatory management practices and their elimination from the workplace should form a central component of training, to help ensure that cultural barriers to practice in individual specialties are reduced.
- Concerted efforts should be made to encourage medical practitioners to report all instances of discriminatory behaviours, and these be appropriately handled through use of robust grievance procedures.

FAMILY AND MEDICAL PRACTICE

Medicine has traditionally been, and continues to be, a highly demanding profession. This includes long working hours beyond that of many other types of employment. As recently as 2013 the IMO undertook industrial action in protest at doctors' work weeks, which were routinely in excess of the forty-eight hour legal limit, and shifts in excess of twenty-four hours. This industrial action had a positive effect in forcing greater compliance with legal working-time limits. In spite of this improved compliance, however, many doctors in Ireland continue to long hours at high intensity, providing poor opportunities to effectively strike a strong work-life balance in which family commitments can be appropriately met.

A recent examination of stressors of Irish doctors observed that "relationship commitments and/or planning a family are surrendered to career demands" and that this serves as one of the principal stressors of medical practitioners in this country, with such stressors recognised as contributing to burnout and mental health difficulties.²¹

These findings are supported by responses to the IMO Survey on Gender Issues in Irish Medicine, which demonstrate serious concerns on the part of medical practitioners about their abilities to balance work and family commitments at present. It is evident that a high level of anxiety exists within the body of Irish doctors about the impact that having children may have on their careers. 82% of female respondents, and 39% of male respondents, said they were concerned about the impact that having children may have on their careers in medicine. Additionally, 46% of female respondents, and 19% of male respondents, said they had postponed having children for reasons related to their careers in medicine. While these concerns affect a significant number of doctors in Ireland of both genders, it is evident that they are far more prevalent amongst female doctors.

There was a strong expression, conveyed through responses, that current support structures within Irish medicine are insufficient to effectively facilitate the appropriate balancing of family and clinical commitments. 83% of female respondents, and 73% of male respondents, said they found it difficult to balance their family commitments with their medical workloads.

21 B. Hayes, D. Fitzgerald, S. Doherty, *et al.*, 'Quality care, public perception and quick-fix service management: a Delphi study on stressors of hospital doctors in Ireland', *BMJ Open* 2015;5:e009564.

Pregnancy, Childcare, and Medical Practice

Of those doctors who had been pregnant or had taken maternity leave, there was significant variance in the quality and effects of their experiences. Many respondents expressed that their experiences during pregnancy, or on return from maternity leave, were positive, or did not negatively impact their careers, perhaps other than it being *“hard work juggling [it] all”*. Some noted that they had made alterations to their work practices following pregnancy with one female respondent noting that: *“by choice, I worked less hours with small children, this set my career back by 10 years, but that was my choice”*. Another observed that the process of being pregnant had a positive impact on her outlook and as a result she had *“[m]ore empathy for patients, [could a]ppreciate anxiety in [the doctor’s] waiting room, [and a]ppreciate the value of kindness in consultation”*. Other doctors had a more negative experience of pregnancy and returning from maternity leave in medicine.

Numerous examples were cited by various respondents of barriers or challenges that were placed in front of them by colleagues, as a result of their pregnancies. One respondent commented:

“During my first pregnancy, I was accepted onto the HST. My maternity leave was due to start [a number of] weeks after I took up my post. I was asked to consider reapplying the following year for HST even though I had already accepted the placement. I received several very upsetting phone calls . . . asking me to . . . consider the effects of the stress of starting a new job [and] commuting on my pregnancy and how I would feel if I had a bad obstetric outcome”.

Another respondent cited the differences in her experiences during two separate pregnancies:

“My first pregnancy I was a reg, the consultants were great, no issue and no discrimination. [During a subsequent pregnancy I was] ill and while the majority of my colleagues were great, my . . . boss was very erratic going from kind to downright discriminatory, citing examples of other women who were able to do tasks that I wasn’t physically able to etc etc. If it wasn’t for the support of the [occupational] health doctor in my hospital I would have felt, and even still did on occasion, feel very vulnerable.”

A negative attitude towards family commitments persisted after the immediate return to work from maternity leave in some instances. One female respondent remarked:

“I [was] told I should not prioritise my family or discuss them in work. There were times when I felt I had absolutely no support as a professional doctor and a mother and there was no recognition that one could affect the other. Obviously the work place is for work but an acknowledgement of the difficulties faced by working mothers and increased flexibility in the workplace are long overdue in medicine as a whole.”

Overall, 18.4% of respondents to the IMO Survey on Gender Issues in Irish Medicine, who had been pregnant whilst employed as a medical practitioner, reported that their employer was not supportive of their pregnancy. This represents a significant portion of female medical practitioners, and indicates that the experience of pregnancy during medical practice for many doctors is negative.

Of concern also was the fact that, of the surveyed doctors who had been pregnant, 84% stated that no member of staff discussed their pregnancies with them to ascertain whether health risks arising from the performance of their workplace duties existed. This appears to represent a potential threat to the health of individual female doctors and workplace health and safety.

Workplace Supports

Overall, 84% of female respondents felt that existing workplace supports do not adequately provide for an opportunity to balance doctors' medical workload with their commitments to their families. These varied from complaints about the attitude and responses of co-workers and superiors, to insufficient statutory supports for fathers to take a more meaningful role in child care immediately following their child's birth, to access to part-time or flexible training or work. Respondents offered numerous suggestions as to the ways in which the quality and variety of supports available to doctors could and should be improved. Suggestions included:

"Be able to step off a scheme, and work as a locum (ie continue to be able to pay a mortgage), for a period of a year, without it being a big issue or held against you. One should also not have to justify the reason why they need the break."

"Facility for a small number of trainees for a short period of time to be involved in part time training. There should be more places made available."

"Better staffing would lead to less individual work load, reduced amount of call and reduce everybody's hours to a more family/life friendly level."

"The opportunity to do BST and HST training part time over a longer period of time. Possibly also job sharing."

"On site crèche facilities [and] adjustment of working hours to facilitate getting young children to and from childcare"

21% female respondents said they had applied for part-time work, however of those that had applied, roughly one-quarter had their applications rejected. By comparison, only 4% of male respondents had applied for part-time work in the past. Some respondents suggested that a culture exists within clinical practice that discourages male practitioners from applying for part-time work and that, in the words of one male respondent, there needs to be *"more acceptance of part time work by male doctors"* within the health system.

One female respondent remarked:

"I feel that male consultants may not actually get the same opportunity as female consultants to apply for job sharing/parental leave etc. I take parental leave and many of my male colleagues who have children often tell me they wish they could take it and be with their children but feel that they would be looked upon as trying to escape work. It seems to be easier for female doctors who are mothers to take it."

Others also remarked that the comparatively short period of two weeks of paternity leave, to which fathers are entitled after the births of their children ought to be extended to provide a more meaningful opportunity to provide childcare in the immediate aftermath of their children's births.

Supporting a Balance between Family Life and Medical Training and Practice

Practice in medicine must not be mutually exclusive from a healthy work-life balance, or the ability to comfortably meet family commitments. It is clear from the responses to the IMO Survey on Gender Issues in Irish Medicine, and from other research in this field, that concerns regarding family commitments and work-life balance operates as a behavioural determinant in specialty choice, and difficulties experienced during pregnancy or managing family commitments clearly exercises an unwelcome influence over many doctor's lives. Included in the recommendation of Strategic Review of Medical Training and Career Structure (established with a view to improving graduate retention in the public health system, planning for future service needs and realising maximum benefit from investment in medical education and training) was the introduction of more flexible family friendly options during training and in consultant posts.

To support a balance between family life and medical training and practice, the IMO recommends:

- Flexible family friendly options in medical training and consultant posts to include options for part-time work and job-sharing as well as the possibility to take parental breaks and job-sharing.
- Discussions should be held between management and doctors who are pregnant, in all instances, to ascertain whether health risks arising from the performance of workplace duties exist, and what other supports should be put in place during a doctor's pregnancy.
- The HSE should investigate the suitability of on-site crèche or child-minding provisions at its premises to better facilitate ease of access to childcare for doctors who are parents.

CONCLUSION

While enormous strides have been made in improving gender diversity and equality within medical practice, key areas remain problematic. Our health services must ensure that all medical practitioners are protected from discrimination on the basis of their gender, and that harmful behaviours that undermine the dignity and welfare of those providing care to patients are eliminated from the workplace. Gender disparities within individual fields of medical practice and barriers to practice in specific specialties should be reduced. Efforts must also be made to improve work-life balance and allow medical practitioners to reasonably meet their family commitments, through extended supports and revised management practices. While the recommendations set out in this paper are not exhaustive their adoption would nevertheless significantly improve the quality of the working lives of doctor in Ireland and help build a more equal and inclusive environment in which our doctors can work.

SUMMARY OF RECOMMENDATIONS

Gender-based Bullying, Gender-based Harassment, and Sexual Harassment

The IMO welcomes the establishment of a Joint Working Group (JWG) under the Respect Charter committed to taking all actions necessary to ensure a culture of respect and collaboration in medical practice and education. The outcomes of the working group should:

- Identify the extent of gender-based bullying, gender-based harassment, and sexual harassment experienced by doctors
- Ensure that doctors in managerial roles, educational roles as well as those in clinical and training roles understand and identify the nature and consequences gender based bullying, gender-based harassment and sexual harassment
- Ensure that appropriate policies and procedures are in place to address all forms of bullying and harassment and that barriers to reporting are removed.

The diversity of the reported sources of gender-based bullying, gender-based harassment, and sexual harassment indicate that a multi-faceted approach to addressing inappropriate behaviours.

- Actions identified by the working group, where possible, should be extended to hospital management and other healthcare professionals.
- Educational campaigns should also ensure that patients are aware of what constitutes gender-based bullying, gender-based harassment, and sexual harassment.

Addressing Gender Issues in Specialty Choice and Career Progression

- A comprehensive analysis should be conducted by the HSE of the reasons for underlying the gender disparities within individual medical specialties, both at senior practitioner and trainee levels. This review should encompass an assessment of work-life balance within all medical specialties, and the role it may have in specialty choice.

- Recruitment efforts should be made to encourage equal gender representation within all medical specialties, targeting in particular those specialties in which the underrepresentation of one gender is clearly evident.
- Training on discriminatory management practices and their elimination from the workplace should form a central component of training, to help ensure that cultural barriers to practice in individual specialties are reduced.
- Concerted efforts should be made to encourage medical practitioners to report all instances of discriminatory behaviours, and these be appropriately handled through use of robust grievance procedures.

Supporting a Balance between Family Life and Medical Training and Practice

- Flexible family friendly options in medical training and consultant posts to include options for part-time work and job-sharing as well as the possibility to take parental breaks and job-sharing.
- Discussions should be held between management and doctors who are pregnant, in all instances, to ascertain whether health risks arising from the performance of workplace duties exist, and what other supports should be put in place during a doctor's pregnancy.
- The HSE should investigate the suitability of on-site crèche or child-minding provisions at its premises to better facilitate ease of access to childcare for doctors who are parents.

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