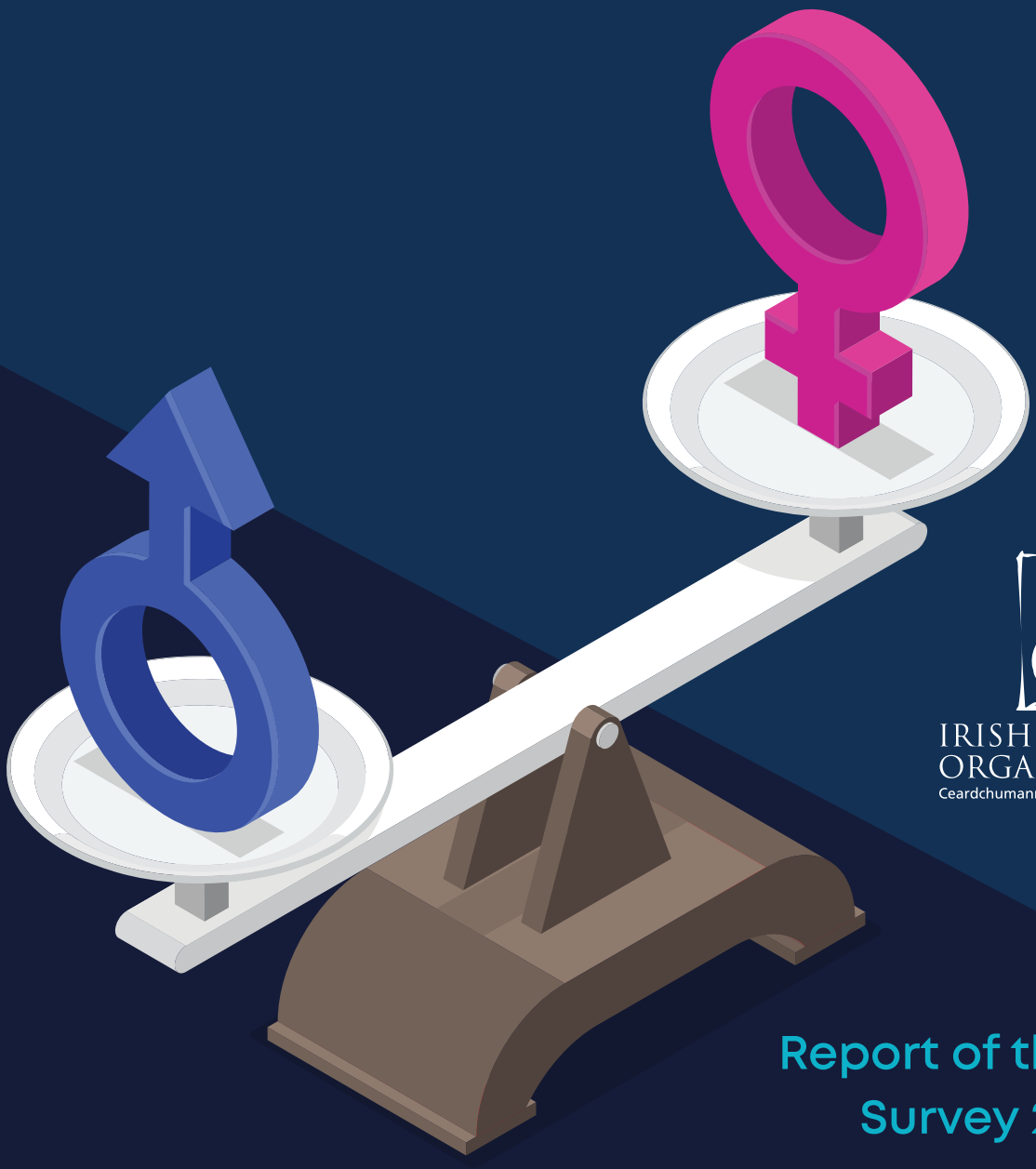

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Report of the IMO Survey 2021 on

Gender Equality in Irish Medicine

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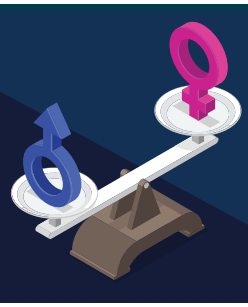
Contents

Key Findings



Key facts in relation to Gender Inequalities in Irish Medicine

We know that for those pursuing a career in medicine, a number of significant gender inequalities exist for example:

- Over the last 5 years the gender breakdown in training has broadly been 56% female and 44% male, yet when we look at the gender breakdown in HSE consultant posts 60% are male and 40% are female;[1]
- Females tend to be over-represented in specialties such as Public Health, Obstetrics and Gynaecology, Paediatrics, Pathology and General Practice, and under-represented in Surgical Specialties, Emergency Medicine and Anaesthesiology;
- CSO figures show that the median earnings of female medical practitioners is 31.5% less than male medical practitioners.[2]

Key Findings from the IMO Survey on Gender Equality in Irish Medicine

The IMO Survey was open to all doctors in Autumn 2021 in order to assess the multiple factors that contribute to gender inequalities in medicine in Ireland. We received a significant response to the survey with 1,615 doctors across all age groups. 70.5% of respondents were female, 28.2% were male, 1.1% preferred not to say, and 0.19% identified as non-binary or transgender.

Dependent Relatives and Parental Leave

More than half the workforce (55.7%) have children, but the demands of balancing family and career impact on males and females differently.

- Of those doctors with children or a dependent relatives in this survey, the majority of females (92%) had taken leave of some kind to care for their children or dependent relatives compared with just 29.4% of males;
- Female doctors are more likely to reduce their hours to part-time (35.8%) or take unpaid leave (25.5%) in order to care for children compared with male doctors (7.2% and 6.8% respectively);
- Almost half of females felt pressure to return to work earlier than they would have liked compared with less than a quarter of males;
- Approximately 29% of males and 24% of females stated that their employer did not provide adequate cover in their absence;
- Upon returning to work, a small but significant portion of female doctors found that their role had altered (7.6%) or the location had changed (9.4%) compared with 1.3% of males;
- 26 doctors had left the Medical Council register for one or more years to care for a dependent relative, 25 of whom were women.

1 HSE - National Doctors Training & Planning, Medical Workforce Report 2021-2022 |

2 CSO, 2019 – Median Earned Income by Occupation 2016, in Women and Men in Ireland 2019 – Gender Equality, https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2019/genderequality/

Childcare

Responsibility for childcare within the family unit also impacts on an individual's ability to balance work and family life.

- Half of male doctors and 41.5% of female doctors with children state that they share responsibility for childcare equally with their partner or spouse;
- However, 46.5% of female doctors report that they are either mainly or fully responsible for childcare within families, in comparison to just 6.3% of male doctors;
- Both male and female doctors report experiencing difficulties in accessing child care - 51.2% of female doctors and 39.1% of male doctors state that they often experience difficulty in sourcing childcare options that fit their working hours;
- 78% of all doctors with children believe the HSE should provide childcare facilities on site, in line with expected working hours.

Pregnancy and Breastfeeding

One third of respondents reported being pregnant while practicing as a doctor.

- Of those, 89% stated that no health and safety assessment was carried out in relation to their pregnancy, with 68% stating that restrictions to working hours, shift work, night work in relation to their pregnancy were not respected;
- Of those breastfeeding, 2 in 5 doctors said that their employer was not at all supportive;

Bullying and Harassment

Three-quarters of doctors who responded to our survey believe bullying and harassment in medicine is a serious issue.

- At some point in their career, 57.4% of respondents, reported having experienced workplace bullying, 41.5% reported having experienced gender-based harassment and 32.4% reported having experienced sexual harassment of which just less than half reported recent experiences within the last 2 years;
- High rates of bullying were experienced by both male and female doctors, however, 53.6% of female and 12.4% of male doctors reported having experienced gender-based harassment, and 39.8% of female and 13.8% of male doctors reported having experienced sexual harassment in the workplace;
- It is also evident that doctors experience bullying and harassment on more than one occasion and from more than one source;
- When we look at experiences in terms of a perpetrator, 43.7% of doctors have experienced bullying by another doctor and 19% have experienced bullying from another health care professional;
- Experiences of bullying and harassment are significantly higher than reported 5 years ago.

Gender Discrimination

Three-quarters of doctors also believe that gender discrimination in medicine is a serious issue.

- 45.8% of female and 10.4% of male doctors have experienced relegation to fewer or more mundane tasks compared to colleagues of another gender, and 26.7% of females and 10.9% of males have been told directly or indirectly that your gender need not apply for a post/career choice;
- In terms of reporting the incidents, just 2.8% said that they had reported the incident.

Equity of Earnings

Many factors can contribute to the existence of gender pay gaps including educational attainment, career choice and progression, prevalence of fulltime and part-time working, and responsibility for caring roles.

- In relation to the gender pay gap in medicine, 66.7% of female doctors and 40.8% of males believe that on average female doctors earn less than male doctors.

Career Choice

We further asked doctors about the factors that influenced their choice of specialty.

- Factors that equally influenced both male and female doctors included , *'self-appraisal of their skills and attitudes, 'based on experience so far' and 'it's what I always wanted to do'.*
- Females however were strongly influenced by *'more family friendly hours/working conditions', 'better fit with family plans'.*
- Of NCHDs in training with children, 76.4% of females and 36.7% of males have considered changing their career speciality as their current working conditions did not seem conducive to caring for a child.

Leadership Opportunities

- 45.4% of female doctors in comparison to 74.9% of male doctors believe that men and women have equal leadership opportunities in their chosen specialty.

Supports required

We asked doctors about the types of supports required to support women in medicine. Of course gender equality is not just about supporting women and it was widely stated that the additional supports should be the same for all genders.

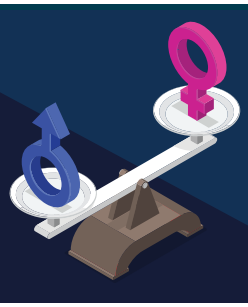
A number of themes emerged including *"more family friendly working options", "better parental leave options," better supports during pregnancy and breastfeeding" More affordable and accessible childcare options", "addressing staffing shortages and better locum availability", "addressing workload including adequate back-filling of roles and less onerous out-of-hour commitments."*

"Cultural change", "gender equality training and addressing unconscious bias" as well as *"better policies for reporting bullying and harassment"* were also highlighted.

Conclusion

The findings of this report indicate the need for more family friendly work options, training and supports, and a general cultural change in medicine so that all doctors can achieve their maximum potential in a more equitable fashion. In particular, the model of post-graduate medical training in Ireland is outdated and is not conducive to supporting an appropriate work-life balance for young doctors, many of whom are of an age where they may be considering to start or already have a family.

Introduction



We know that for those pursuing a career in medicine, a number of significant gender inequalities exist for example:

- Over the last 5 years the gender breakdown in training has broadly been 56% female and 44% male, yet when we look at the gender breakdown in HSE consultant posts 60% are male and 40% are female.[3]
- Females tend to be over-represented in specialties such as Public Health, Obstetrics and Gynaecology, Paediatrics, Pathology and General Practice, and under-represented in Surgical Specialties, Emergency Medicine and Anaesthesiology;
- CSO figures show that the median earnings of female medical practitioners is 31.5% less than male medical practitioners[4]

While gender equality is important from a human rights perspective, there is also increasing evidence, primarily from business and management sectors, that gender-diverse workplaces improve productivity, innovation, decision making, and employee retention and satisfaction. There is also growing evidence that gender equality in medicine may improve patient outcomes.[5]

Despite a growing attention to gender equality, there is little systematic understanding and evidence of the multifactorial sources of gender inequalities in medicine in Ireland and the impact it has on doctors' career prospects and advancement, personal and family life, work-life balance, and their mental and physical wellbeing.

This report captures a broad understanding of the experiences and issues of medical practitioners in Ireland across key areas in relation to gender in medicine, including: Parental/Carer's leave, Childcare, Pregnancy and Breastfeeding, Bullying and Sexual Harassment, Gender Discrimination, Equity of Earnings, Career Choice. We acknowledge many of these issues are linked to a multitude of socio-economic and demographic characteristics, however, this survey sought primarily to address the issues that disproportionately affect women.

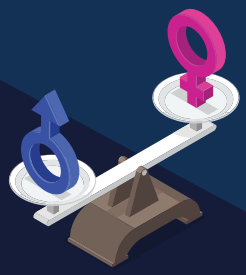
It is the aim of this paper to highlight the gender-related experiences and issues that continue to affect medical practitioners in Ireland, and offer recommendations intended to assist and encourage policy makers and health services management to effectively address these issues, building a health service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

3 HSE - National Doctors Training & Planning, Medical Workforce Report 2021-2022 |

4 CSO, 2019 – Median Earned Income by Occupation 2016, in Women and Men in Ireland 2019, https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2019/genderequality/

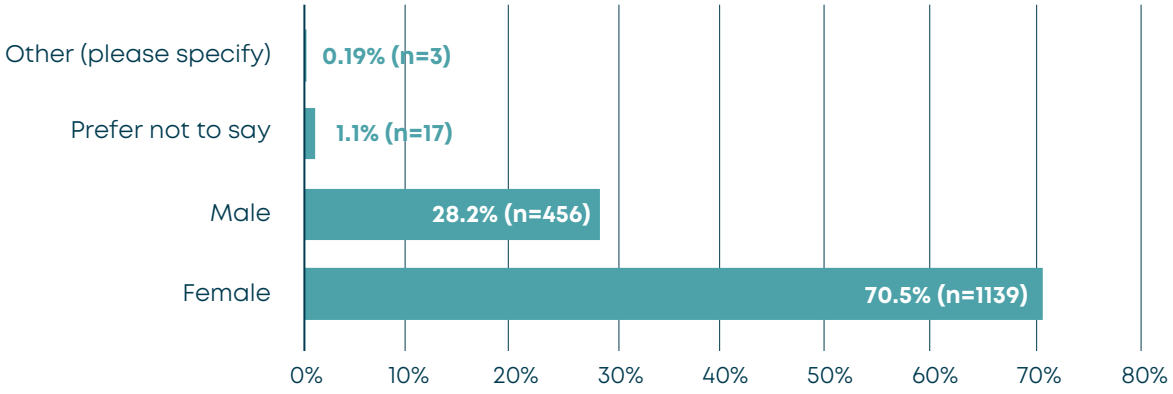
5 Shannon, G., et al, 2019. Gender equality in science, medicine, and global health: where are we at and why does it matter?. The Lancet, 393(10171), pp.560-569. https://www.sciencedirect.com/science/article/pii/S0140673618331350

Response Rate and Demographics



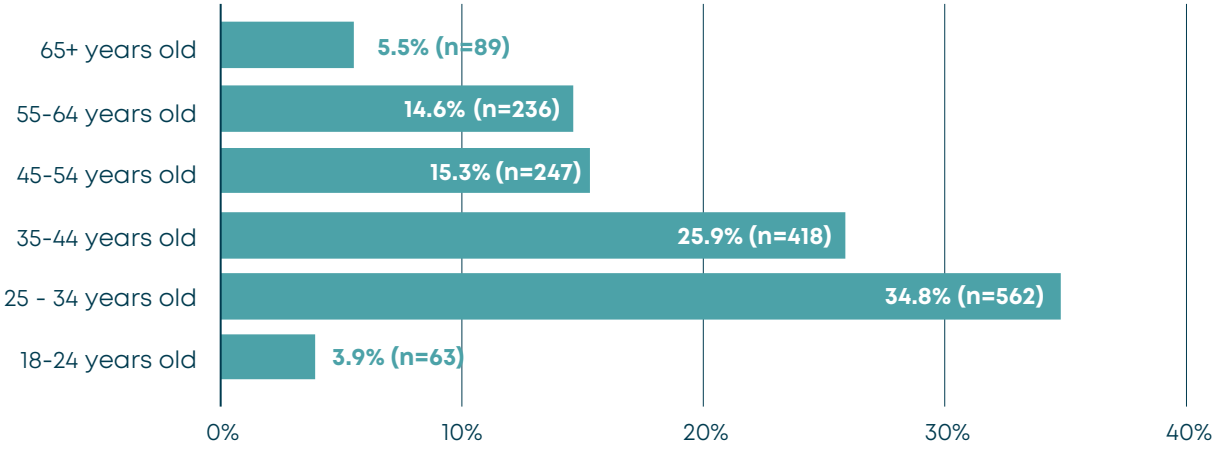
The Irish Medical Organisation (IMO) conducted a large-scale survey of doctors in Ireland, providing insights in relation to issues concerning gender equality and solutions to address these issues. Overall, the survey received 1,615 responses spanning various types of medical practitioners, including NCHDs, Consultants, GPs, Public Health and Community Health Doctors and others.

Respondents, by Gender



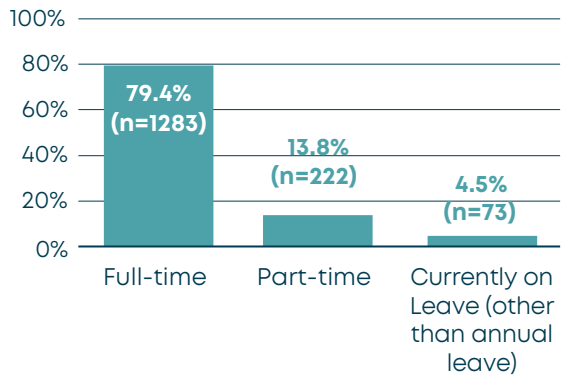
Of the 1,615 responses, 70.5% were female, 28.2% were male, 1.1% preferred not to say, and 0.19% identified as non-binary or transgender.

Age Range



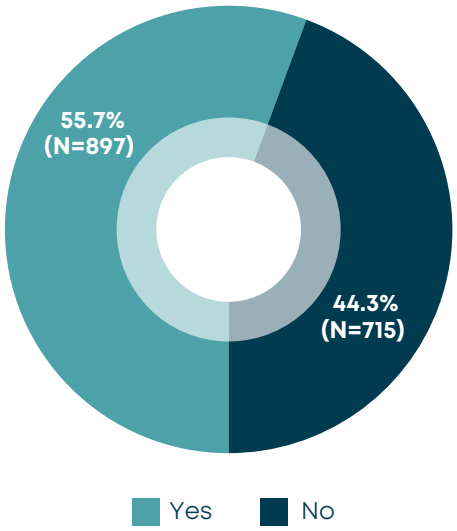
The responses were fairly evenly spread among all age ranges with the highest percentage of respondents in the 25-34 years age-bracket.

Current Working Hours



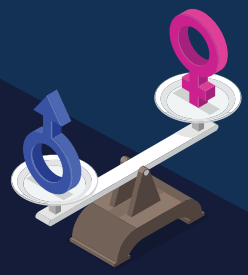
Most respondents (79.4%) at the time of answering the survey working in a full-time capacity, with the remaining respondents working part-time (13.8%) or on leave currently (4.5%).

% of Respondents Who Have or Have Had Children or a Dependent relative



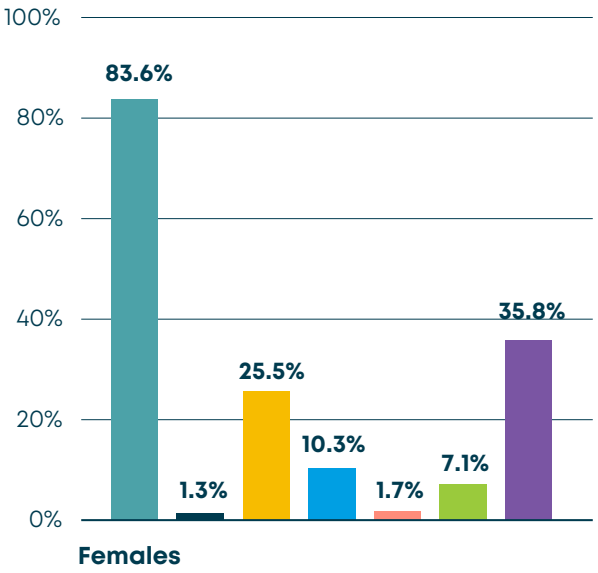
55.7% of respondents in this survey have or have had children or a dependent relative, accounting for 53.1% of females (n=603) and 61.4% of male doctors (n=280)

Parental or Carer's leave



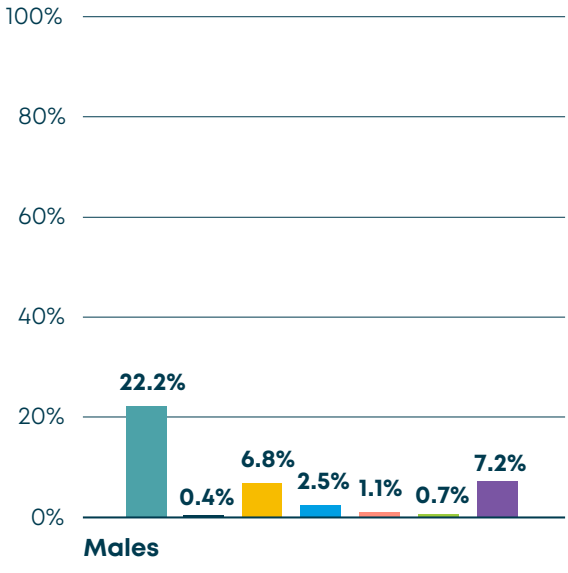
While more than half the workforce have children, the demands of balancing family and career impact on males and females differently.

Leave taken by Female Doctors with Children or Dependent Relatives



- Maternity Leave
- Adoptive Leave
- Unpaid Parental Leave
- Parents Leave
- Carer's Leave
- Career Break
- Reduced Hours/Working Part-time

Leave taken by Male Doctors with Children or Dependent Relatives



- Paternity Leave
- Adoptive Leave
- Unpaid Parental Leave
- Parents Leave
- Carer's Leave
- Career Break
- Reduced Hours/Working Part-time

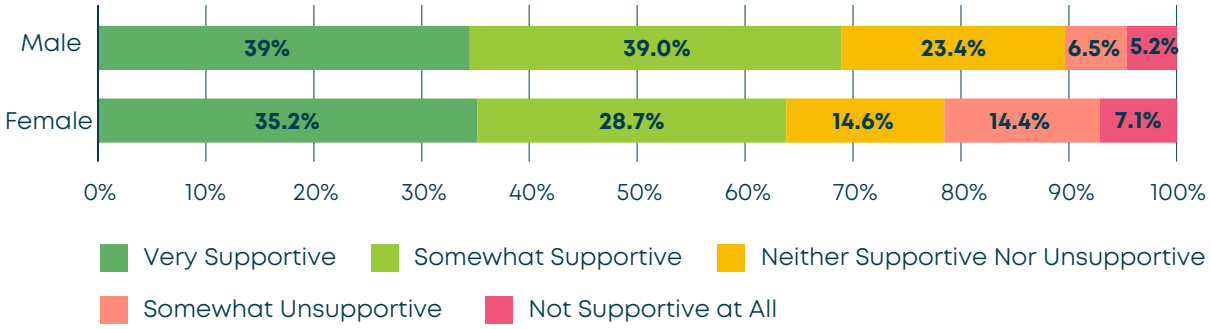
Types of Leave Taken

Of doctors with children or a dependent relative who responded to the survey, 92% of females (n=555) had taken leave of some kind to care for their children or dependent relatives compared with just 29.4% of males (n=83). 83.6% of women had taken maternity leave while just 22.2% of males had taken paternity leave.

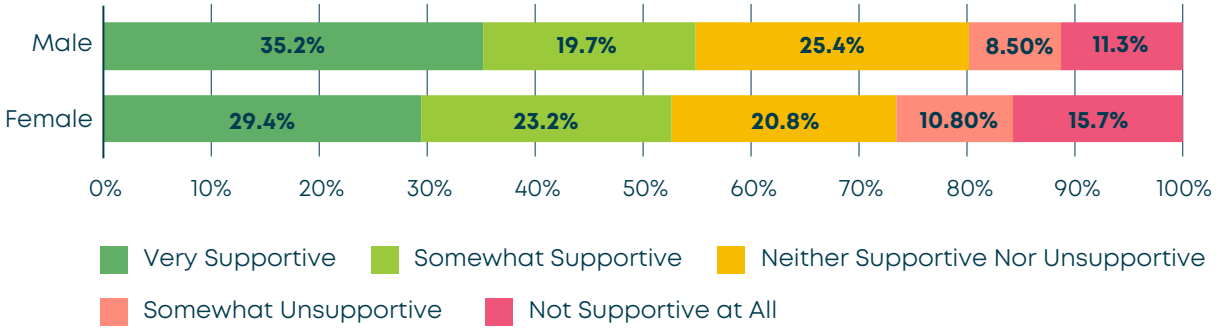
Females were more likely to have taken unpaid parental leave or reduced their hours with 25.5% of females and 6.8% of males taking unpaid leave and 35.8% of females and 7.2% of males reducing their hours or working part-time.

41.7% took leave during training, 1.1% took leave as a student, and 70.8% took leave post-training. By gender, a similar proportion of women (71.8%) in comparison to men (65.4%) of men took leave post-training.

Support Received From Colleagues in Taking Leave or Reducing Hours



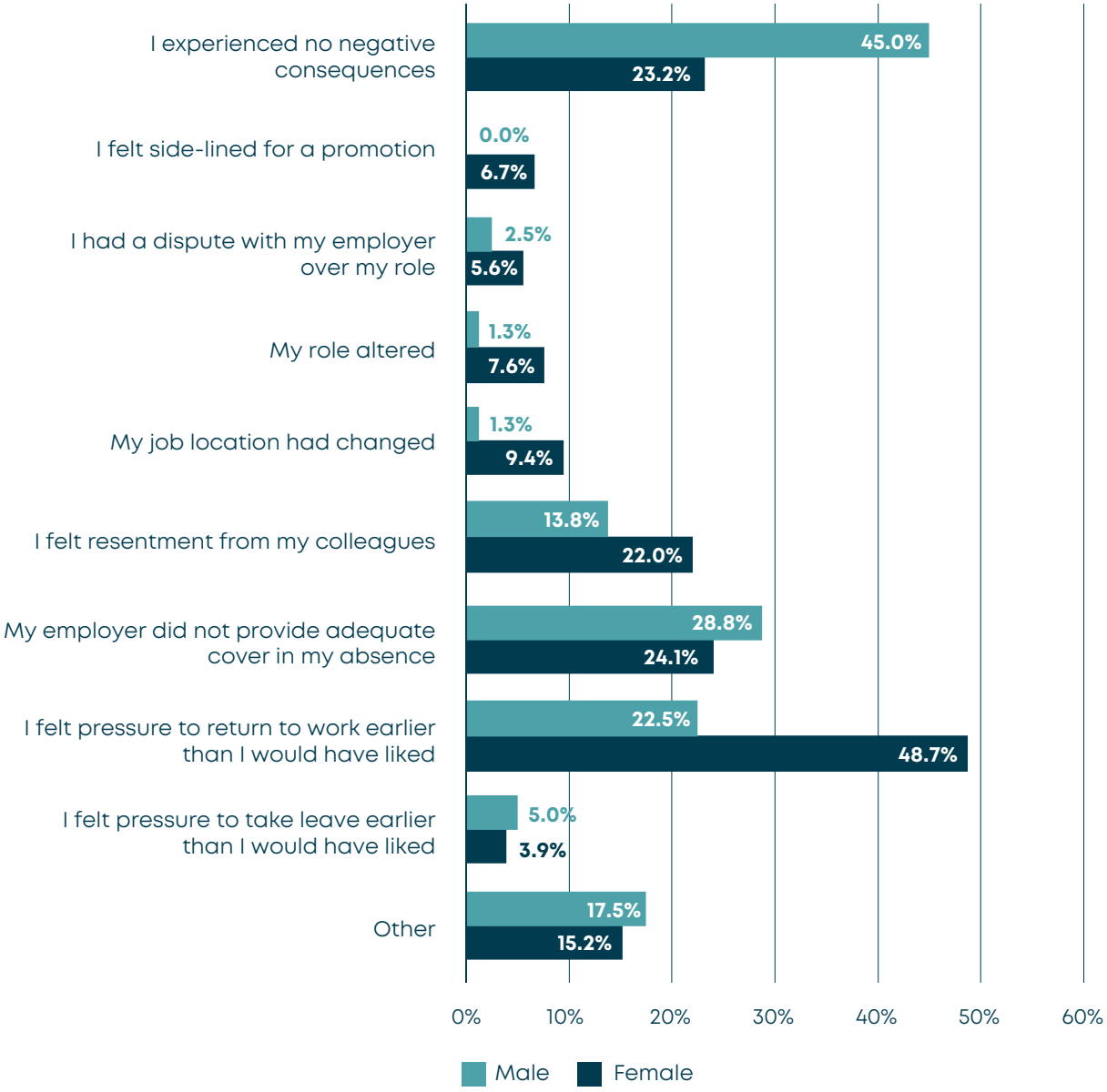
Support Received From Employer in Taking Leave or Reducing Hours



Support Received in Taking Leave or Reduced Hours

In general, most doctors felt supported by both their colleagues and their employer when they took leave or reduced their hours, however more females than males felt unsupported. By gender, 21.5% of female doctors believed their colleagues to be somewhat unsupportive or not to be supportive in comparison to 11.7% of males. In conjunction, 26.5% of female doctors deemed their employer to be somewhat unsupportive or not to be supportive at all, in comparison to 19.8% of males.

Consequences of Taking Leave or Reducing Hours, by Gender



Consequences of Taking Leave or Reducing Hours

Doctors were also asked if they had experienced any negative consequences as a result of taking leave or reducing hours. 45.5% of all respondents who took leave felt pressured to return to work, with 20.9% feeling resentment from colleagues, and 24.9% stated that their employer did not provide adequate care in their absence.

- Almost half (48.7%) of female doctors felt pressure to return to work earlier than they would have liked compared with less than a quarter (22.5%) of male doctors;
- Approximately 29% of males and 24% of females stated that their employer did not provide adequate cover in their absence;
- While a small but significant portion of female doctors found that their role had altered (7.6%) or the location had changed (9.4%) compared with 1.3% of males.

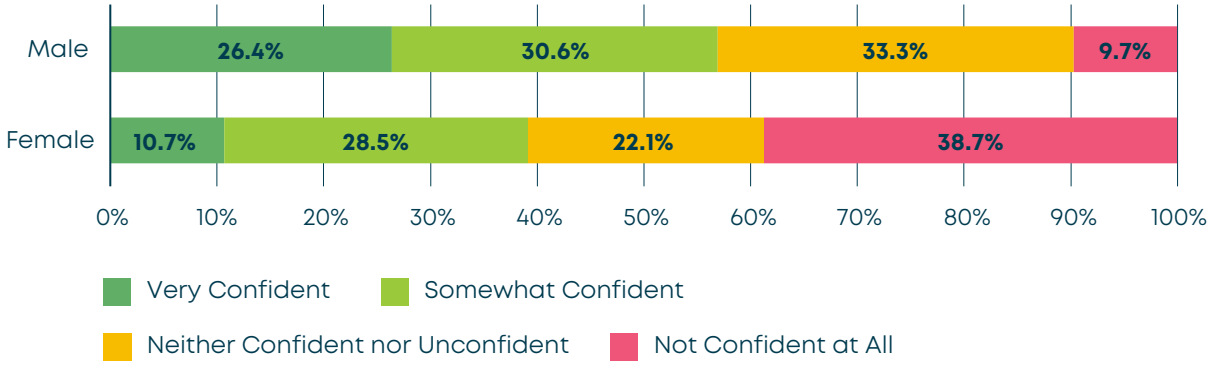
In capturing the downfalls in taking maternity leave, one account documents: *'I worked up until the morning I went into labour as a sessional GP and returned to work after 10-12 weeks and still feel guilty that I missed out time at home with my new born baby.'* Other experiences in relation to taking maternity leave include the *'presumption I would work less as I had children'*, and *'made to feel that being pregnant and having to adjust some (very few) clinical duties was a complete hindrance'.*

26

Doctors left the Medical Council Register to care for a dependent relative

26 respondents had left the Medical Council Register to care for a dependent relative, 13 left for one year while a further 13 left for two or more years. All except one were female doctors.

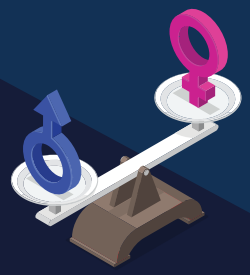
Degree of Confidence in Negotiating Leave/Terms and Conditions



Negotiating Leave and Terms/Conditions

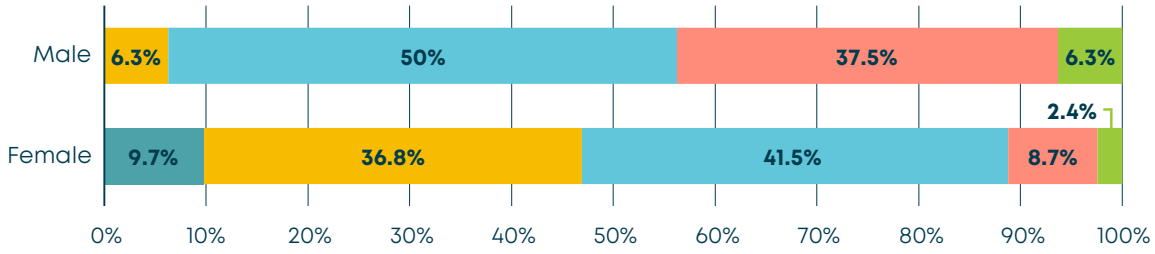
In terms of confidence in negotiating leave and terms and conditions, male doctors reported significantly higher confidence in negotiating than females with 57% of males feeling very confident or somewhat confident while 38.7% of females did not feel confident at all.

Childcare Responsibilities and Services



Responsibility for childcare within the family unit also impacts on an individual's ability to balance work and family life while difficulties relating to affordability and accessibility of childcare can also impact on career decisions.

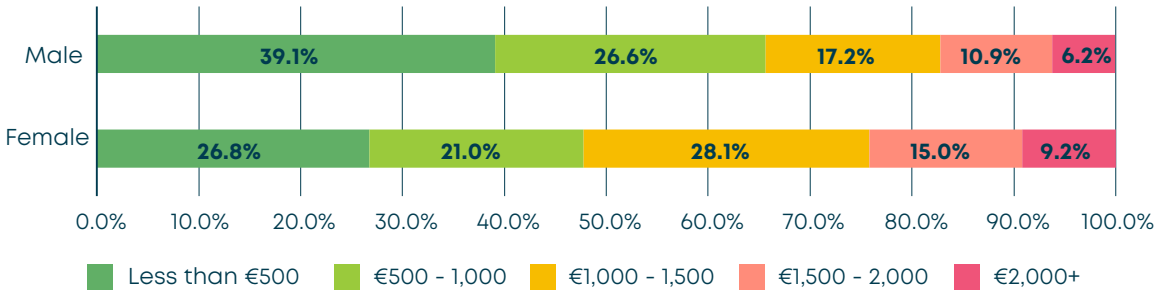
Responsibility for Childcare Within Families



Childcare Responsibility Within Families

50% of male doctors and 41.5% of female doctors state that they share responsibility for childcare equally with their partner or spouse. By gender, no male doctors in the survey said they have sole responsibility of childcare, with almost 1 in 10 (9.7%) females doctors stating they have sole responsibility. A further 36.8% of females doctors state that they are mainly responsible for childcare compared with 6.3% of male doctors.

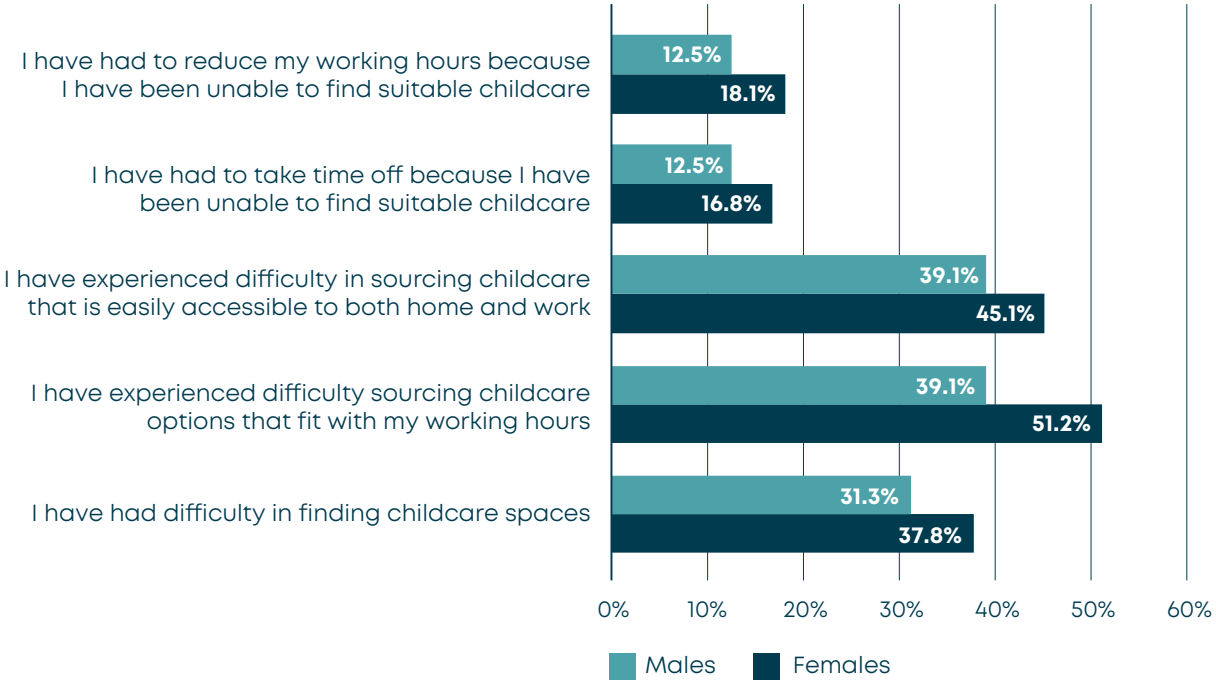
Cost of Childcare Per Month

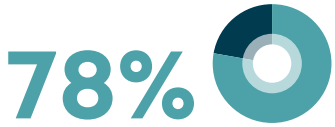


Affordability of Childcare Services

With regards to the cost of formal childcare, over half of all respondents requiring childcare (50.1%) are spending over €1000 a month on childcare services. By gender, over half of females (52.3%) and over one third of males (34.3%) stated that they spend over €1000 per month on childcare.

Difficulties Experienced by Doctors in Accessing Childcare Services





78%

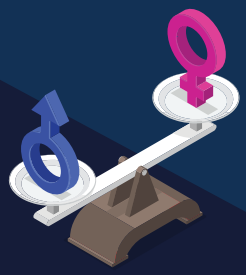
of doctors with children believe the HSE should provide childcare facilities on site

78% of doctors with dependent children believe the HSE should provide childcare facilities on site in line expected working hours.

Accessing Suitable Childcare

Both male and female doctors experienced significant difficulties in accessing childcare. 51.2% of female doctors and 39.1% of male doctors report experiencing difficulty in sourcing childcare options that fit their working hours. This experience is similarly related to finding childcare that is easily accessible to both work and home. In terms of negative consequences, 18.1% of women and 12.5% of men with children have often had to reduce hours due to being unable to find suitable childcare.

Pregnancy and Breastfeeding



Pregnancy is part of normal life. Most women work while pregnant and return to work while still breastfeeding. 550 female doctors (one third of respondents) offer their experience of pregnancy and breastfeeding in Ireland within the workplace. Within this survey of doctors, of those doctors who had been pregnant and had taken leave, experiences in taking leave, the workplace assessments, and supports offered differed substantially.

89%

of doctors stated that no health and safety assessment was carried out in relation to their pregnancy

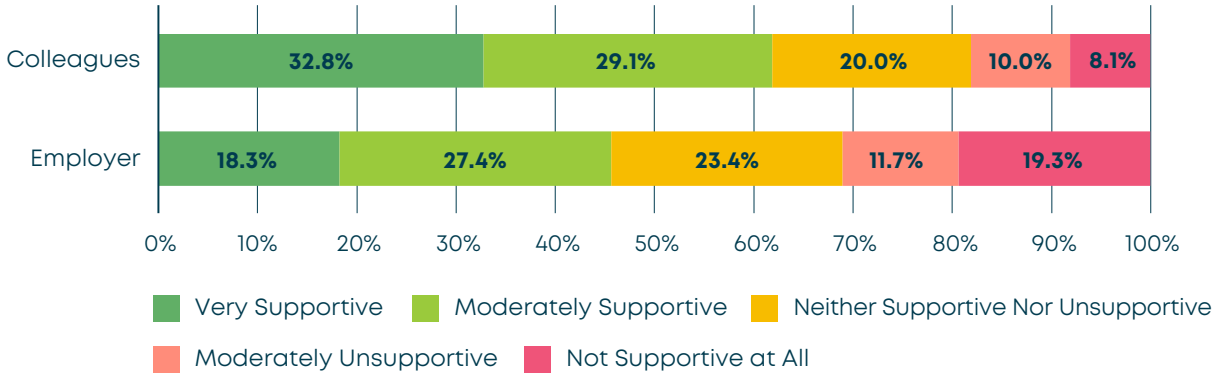
68%

of doctors stated that restrictions to working hours, shift work, night work in relation to their pregnancy were not respected

Health and Safety

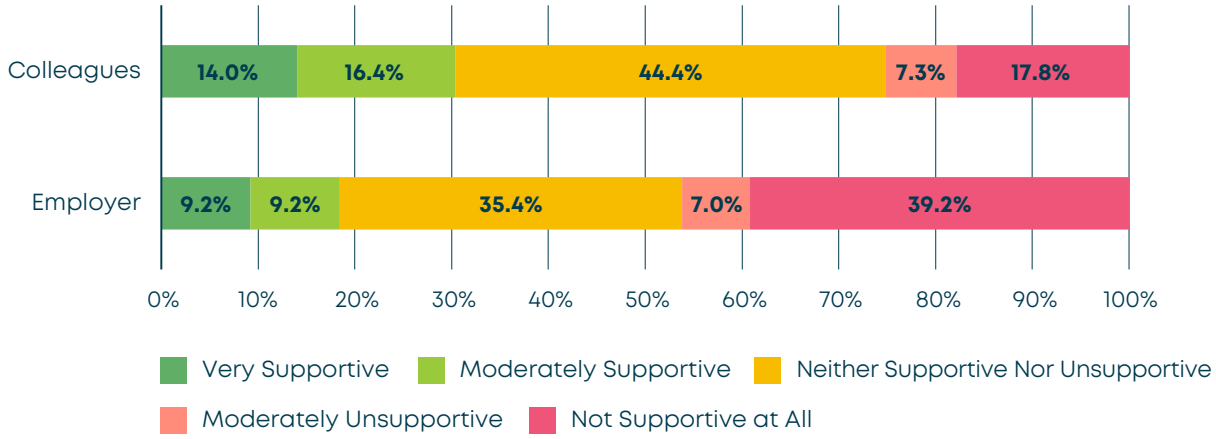
The Safety, Health and Welfare at Work (General Application) Regulations, 2007[6], requires an employer to identify all hazards and assess any risks to the safety or health of a pregnant employee. Of doctors to whom this applied, 89% said that no health and safety assessment was carried out in relation to their pregnancy and 68% stated that the restrictions to working hours, shift work, night work in relation to their pregnancy were not respected.

Degree of Support Received During Pregnancy



6 https://www.irishstatutebook.ie/eli/2007/si/299/

Degree of Support Received During Breastfeeding

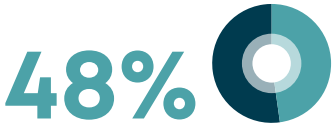


Support Received during Pregnancy and Breast-feeding

The majority of doctors (61.9%) felt that their colleagues were moderately supportive or very supportive with regards to their pregnancy, with just 8.1% who felt that colleagues were not supportive at all. However, many did not feel that same support from their employer with almost 1 in 5 (19.3%) stating that their employer was not supportive at all.

In relation to breastfeeding, doctors deemed their colleagues and employers to be less supportive. 17.8% felt that their colleagues were not supportive at all while they were breast-feeding and 39.2% stated that their employer was not at all supportive.

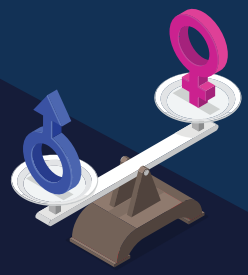
In November 2020, the HSE adopted a new breastfeeding policy enabling breastfeeding mothers to avail of breastfeeding breaks up to the child's second birthday.[7] Of those who had been breastfeeding in the previous 6 months, only around half (52%) were aware of the HSE Breastfeeding Policy, with 48% not being aware of the policy.



of doctors who were pregnant in the previous 6 months were not aware of the new HSE Breastfeeding Policy

7 HSE 2020, Breastfeeding Policy for Staff Working in the Public Health Service https://healthservice.hse.ie/filelibrary/staff/breastfeeding-policy-for-public-health-service-employees.pdf

Bullying and Harassment



Bullying and harassment can impact negatively on an individual's well-being, causing stress and undermining self-confidence. It can also negatively impact on performance and lead an individual to leave their employment. Under the Safety, Health and Welfare at Work Act 2005 (as amended) employers must "prevent any improper conduct or behaviour likely to put the safety, health and welfare of employees at risk", including bullying. While employees are protected from harassment, including sexual harassment under the Employment Equality Act 1998-2015, employers are required to have policies in place for preventing and dealing with complaints of bullying[8] and complaints of harassment[9].

3/4

of doctors believe bullying and harassment in medicine is a serious issue

Doctors were asked a number of questions about their experience of bullying, gender-based harassment and sexual harassment in the workplace. Almost three-quarters (74.4%) of respondents feel that Bullying and Harassment in medicine is either a moderately serious or very serious issue.

Definitions

Workplace 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".

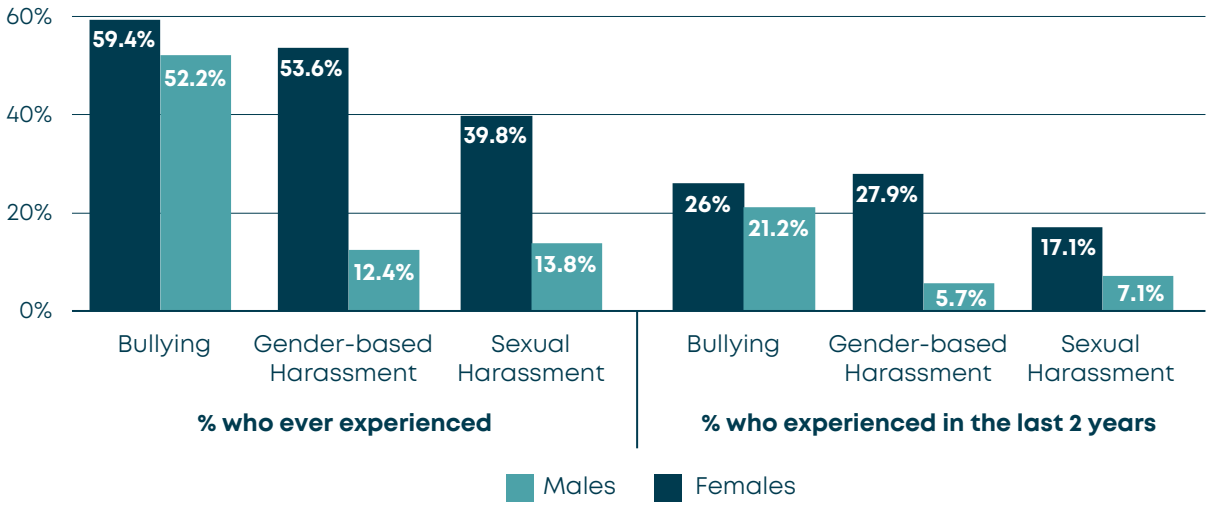
Gender-based harassment is defined as: "unwanted conduct related to gender, which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person".

Sexual harassment is defined as: "unwanted verbal, non-verbal or physical conduct of a sexual nature, 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."

8 Health and Safety Authority and Workplace Relations Commission 2021, Code of Practice for Employers and Employees on the Prevention and Resolution of Bullying at Work, https://www.workplacerelations.ie/en/what_you_should_know/codes_practice/code-of-practice-for-employers-and-employees-on-the-prevention-and-resolution-of-bullying-at-work.pdf

9 Irish Human Rights and Equality Commission 2022, Code of Practice on Sexual Harassment and Harassment at Work https://www.ihrec.ie/app/uploads/2022/03/Codes-of-Practice-Sexual-Harassment-FA_Digital.pdf

Experiences in the Workplace, by Gender



Experiences of Bullying and Harassment in the Workplace

At some point in their career, 57.4% of all respondents, reported having experienced workplace bullying, 41.5% reported having experienced gender-based harassment and 32.4% reported having experienced sexual harassment. There was little difference in experience of bullying between males and female doctors (52.2% and 59.4% respectively), however, 53.6% of female and 12.4% of male doctors reported having experienced gender-based harassment, and 39.8% of female and 13.8% of male doctors reported having experienced sexual harassment in the workplace.

Experiences in the workplace within the last 2 years	Bullying	Gender-based Harassment	Sexual Harassment
Female NCHDS	38.2%	43.5%	29.3%
Male NCHDs	41.5%	12.5%	16.4%
Total NCHDs	39.2%	35.8%	26.3%
Female Consultant	24.1%	20.3%	6.3%
Male Consultant	21.1%	0%	0%
Total Consultant	22.9%	13.6%	4.2%
Female Community/Public Health	26.8%	4.9%	0%
Male Community/Public Health	14.3%	14.3%	0%
Total Community/Public Health	24.5%	6.1%	0%
Female GP	12.4%	14.1%	7.0%
Male GP	7.7%	1.9%	2.4%
Total GP	10.8%	10.0%	5.5%

Experiences of Bullying and Harassment within the last 2 years

Within the last two years, 24.6% of respondents had experienced bullying in the workplace, while 21.4% had experienced gender-based harassment and 18.1% had experienced sexual harassment. Highest incidents of recent bullying were experienced by both male and female NCHDs (41.5% and 38.2%) while female NCHDs experienced the highest incidents of gender-based harassment (43.5%) and sexual harassment (29.3%) within the last 2 years.

Experience of Bullying and Harassment by Perpetrator	Manager/ Supervisor	Another Doctor	Another HCP	A Patient
Bullying total	15.1%	43.7%	19%	14.1%
Females	14.4%	45.3%	19.7%	14.7%
Males	17.1%	39.3%	17.6%	12.4%
Gender-based harassment total	6.4%	23.9%	8.9%	19.9%
Females	7.9%	31.1%	9.9%	26.3%
Males	3.1%	6.4%	6.2%	4.8%
Sexual harassment total	3.2%	15.2%	3.7%	16.8%
Females	4%	20.3%	2.7%	20.6%
Males	1.2%	2.4%	6.2%	7.9%

Sources of Bullying and Harassment and Reporting

It is also evident that many doctors experienced bullying and harassment on more than one occasion and by different perpetrators.

It is also evident that doctors experience bullying and harassment on more than one occasion and from more than one source.

- When we look at experiences by perpetrator, 43.7% of doctors have experienced bullying by another doctor and 19% have experienced bullying from another health care professional.
- 31% of female doctors reported experiencing gender-based harassment from another doctor and 26% from a patient.
- 20% of female doctors reported experiencing sexual harassment from another doctor and 20% also said they had experienced sexual harassment from a patient.

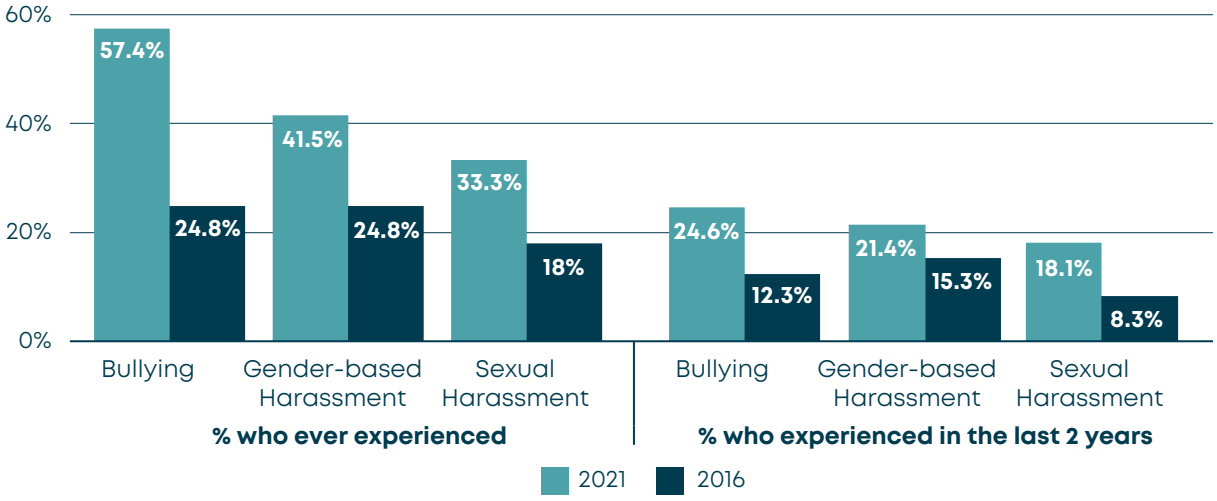
From the survey we cannot tell whether the perpetrators of bullying and harassment are male or female or whether just a few individuals are responsible.

And while significantly high numbers of doctors have experienced bullying, gender-based harassment or sexual harassment, few doctors report their experience.

Overall just 14% of doctors (15% of female doctors and 10.3% of male doctors) reported the incidents. In terms of the reasons given for not doing so, 57.8% overall believed it wasn't worth the hassle, and nearly half (48.6%) felt it wouldn't make any difference. Further, 37.9% believed it would impact on their career progression and training opportunities, and 26% said they were moving on anyway.

For those that did report (15% of female doctors and 10.3% of male doctors), written responses given were largely negative in respect of outcomes: *'A prolonged internal, hospital grievance procedure which was not independent & did not uphold my complaints', 'It was made very clear to me that I was the problem. I did not pursue the issue',* and *'I was told by the clinical director it would be a risk to report it because nothing would come of it, and it would reflect poorly on me'.*

Comparison of Workplace Experiences (2021 and 2016 Gender Equality Surveys)



Comparison with 2016 Survey

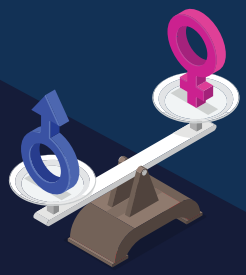
The findings from the 2021 survey show that experiences of bullying, gender-based harassment and sexual harassment are significantly higher by comparison with a similar survey carried out by the IMO in 2016.

Although there were a number of differences between the 2021 survey and the 2016 survey, the response rate in 2021 was significantly higher than in 2016 and is thought to be more representative.

In 2016 survey respondents were asked specifically about bullying based on gender which may account for the difference in results. A more stressful and strenuous working environment may also be a contributing factor to higher numbers of reported bullying.

In relation to harassment, a number of campaigns over the past five years, such as the #MeToo movement, have raised awareness about gender based harassment and sexual harassment and may be a factor in higher reported experiences in 2021.

Gender Discrimination



Gender discrimination is where an employee is treated less favourably than another on the grounds of their gender. Again the Employment Equality Acts 1998-2005 provide certain protections for employees against gender discrimination in the workplace in relation to access to employment, conditions of employment, pay, training or experience for or in relation to employment, promotion or re-grading, classification of posts, dismissal, advertising.[10]

3/4

of doctors believe that gender discrimination in medicine is a serious issue

Over three-quarters (76.2%) of respondents believe gender discrimination to be a moderately serious or very serious issue. By gender, 80.30% of females believe gender discrimination to be either a moderately serious issue or a very serious issue, in comparison to 66.8% of males.

Experiences of Gender Discrimination in the Workplace			
	Females	Males	Total
No. of respondents	(1,010)	(394)	(1,422)
% who have experienced			
Relegation to fewer or more mundane tasks compared to colleagues of another gender	45.8%	10.4%	35.7%
Exclusion from tasks based on your gender	27.9%	20.6%	25.6%
Refusal by a colleague to carry out an assigned task based on your gender	21.4%	7.1%	17.2%
Being told directly or indirectly that your gender need not apply for a post/career choice	26.7%	10.9%	22.1%
Felt passed over for promotion/career progression on the basis of my gender	22.4%	9.2%	18.5%

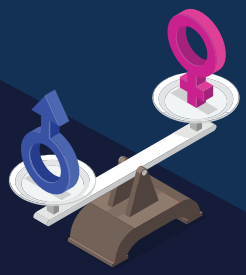
10 Irish Human Rights and Equality Commission, Guide to Taking an Employment Equality Case https://communitylawandmediation.ie/publications/employment-equality-acts/

Experiences of Gender Discrimination in the Workplace

Respondents were asked to select if they had ever experienced incidents from a list of potential gender-based discriminatory acts. Here, the survey indicates that 45.8% of females respondents and 10.4% of males respondents have experienced relegation to fewer or more mundane tasks compared to colleagues of another gender. 21.4% of female doctors and 7.1% of males had a refusal by a colleague to carry out an assigned task based on their gender, and 26.7% of female doctors and 10.9% of male doctors have been told directly or indirectly that your gender need not apply for a post/career choice.

In terms of reporting such incidents, again the vast majority (97.2%) did not do so, with little difference between genders. Overall, 37.7% of those who did not report cited that they felt it would impact on their career progression, 48% stated they felt it wasn't worth the hassle, and 55.8% didn't feel it would make any difference. This was again relatively even between male and female Doctors. An individual account reflects on their view of the system on reporting gender discrimination: *'It feels utterly pointless. Anyone I have ever known who has tried to raise the issue has been made out to be difficult or "the problem".'*

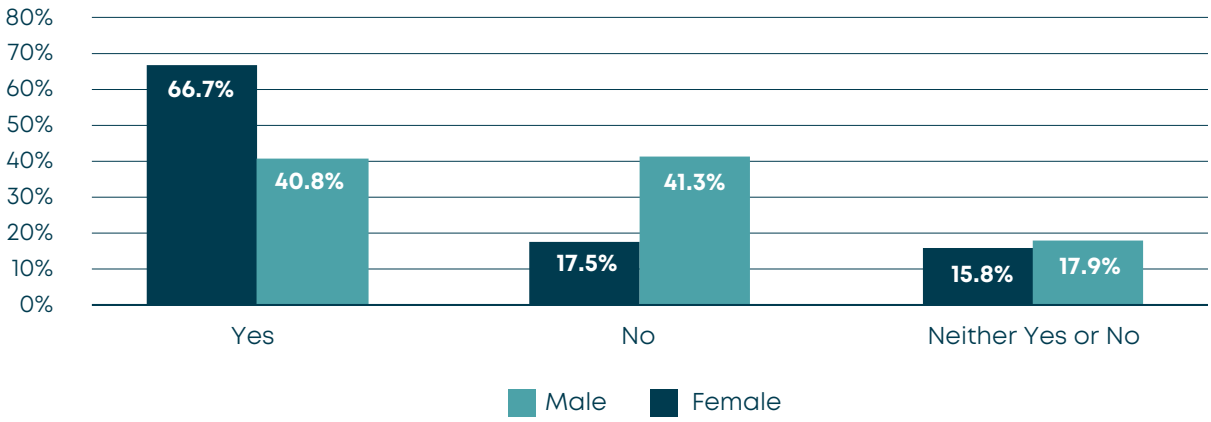
Equity of Earnings



The gender pay gap is not only about equal pay for equal work, which is required under the employment equality legislation, but is a measurement of the difference in average earnings between males and females in a workforce.[11] Many factors can contribute to the existence of gender pay gaps including educational attainment, career choice and progression, prevalence of full-time and part-time working, and responsibility for caring roles. CSO statistics published in 2019 show that the median annual income (not adjusted for hours worked) of female medical practitioners in 2016 was €75,212 , 31.5% less than the median annual income of male medical practitioners of €109,785.[12] From 2022, under the Gender Pay Gap Information Act 2021, certain organisations will be required to report on their gender pay gap across a range of metrics.

Note: The median is considered a more stable measure of the average than the mean as it is less affected by extreme values of a small number of very high or very low earners.[13]

Respondents that 'believe that female doctors earn less than male doctors on average'



Views of Doctors on the Gender Pay Gap in Medicine

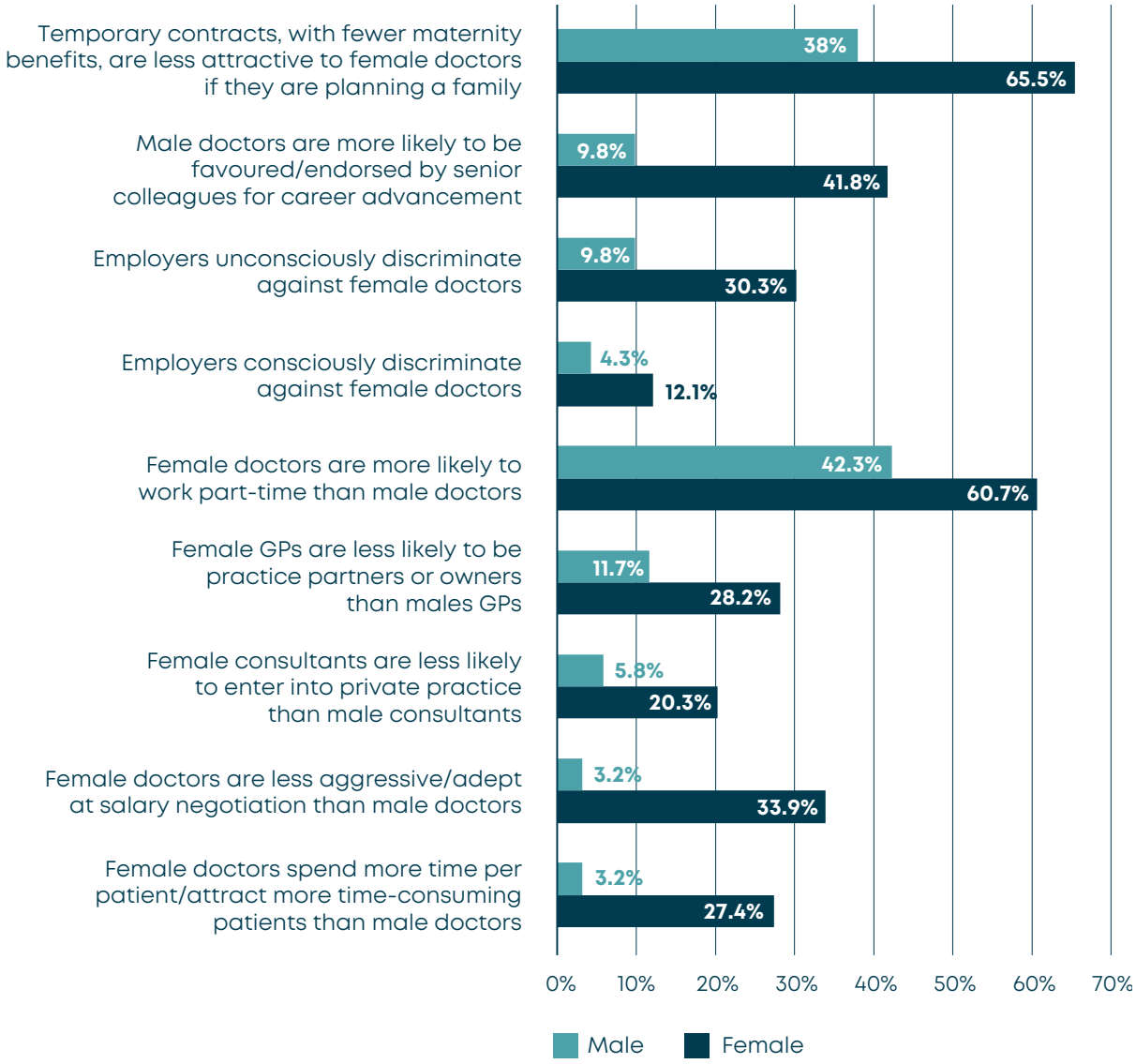
In relation to the Gender Pay Gap in medicine, there is a significant difference of opinion by gender with 66.7% of female doctors believing on average they earn less than their male counterparts and 40.8% of males believe this to be the case. 41.3% of male doctors and 17.5% of female doctors do not believe this, whilst 17.9% of male doctors and 15.8% of female doctors are unsure (neither yes or no).

11 Department of Justice 2020, Report on the Gender Pay Gap https://www.justice.ie/en/JELR/DoJ_GPG_Report.pdf/Files/DoJ_GPG_Report.pdf

12 CSO, 2019 – Median Earned Income by Occupation 2016, in Women and Men in Ireland 2019 – Gender Equality, https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2019/genderequality/

13 Wilson L, 2021 - The Gender Pay Gap in the Republic of Ireland NERI Report Series, No.5, Nevin Economic Research Institute https://www.nerinstitute.net/research/gender-pay-gap-republic-ireland

Contributors of Gender Inequity of Earnings, by Gender

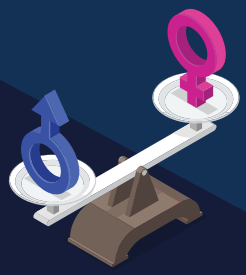


Views of Doctors on Contributions to Gender Pay Gap

Views on the factors that contribute to the gender pay gap also differ between females and males. In terms of a breakdown by gender, 65.5% of female and 38% of male doctors strongly agree that temporary contracts, with fewer maternity benefits, are less attractive to female doctors if they are planning a family, and 60.7% of female and 42.3% of male doctors strongly agree believe that female doctors being more likely to work part-time than male doctors is a contributor.

One of the largest gaps in opinion between female and male doctors was in relation to the belief that male doctors being more likely to be favoured/endorsed by senior colleagues for career advancement is a strong contributor to differences in earnings, with 41.8% of female doctors in comparison to 9.8% of male doctors believing this to be the case. Another significant difference of opinion by gender is the belief that employers unconsciously discriminate against female doctors, with 30.3% of female doctors believing this to be the case in comparison to 9.8% of male doctors overall.

Career Choice and Leadership Opportunities



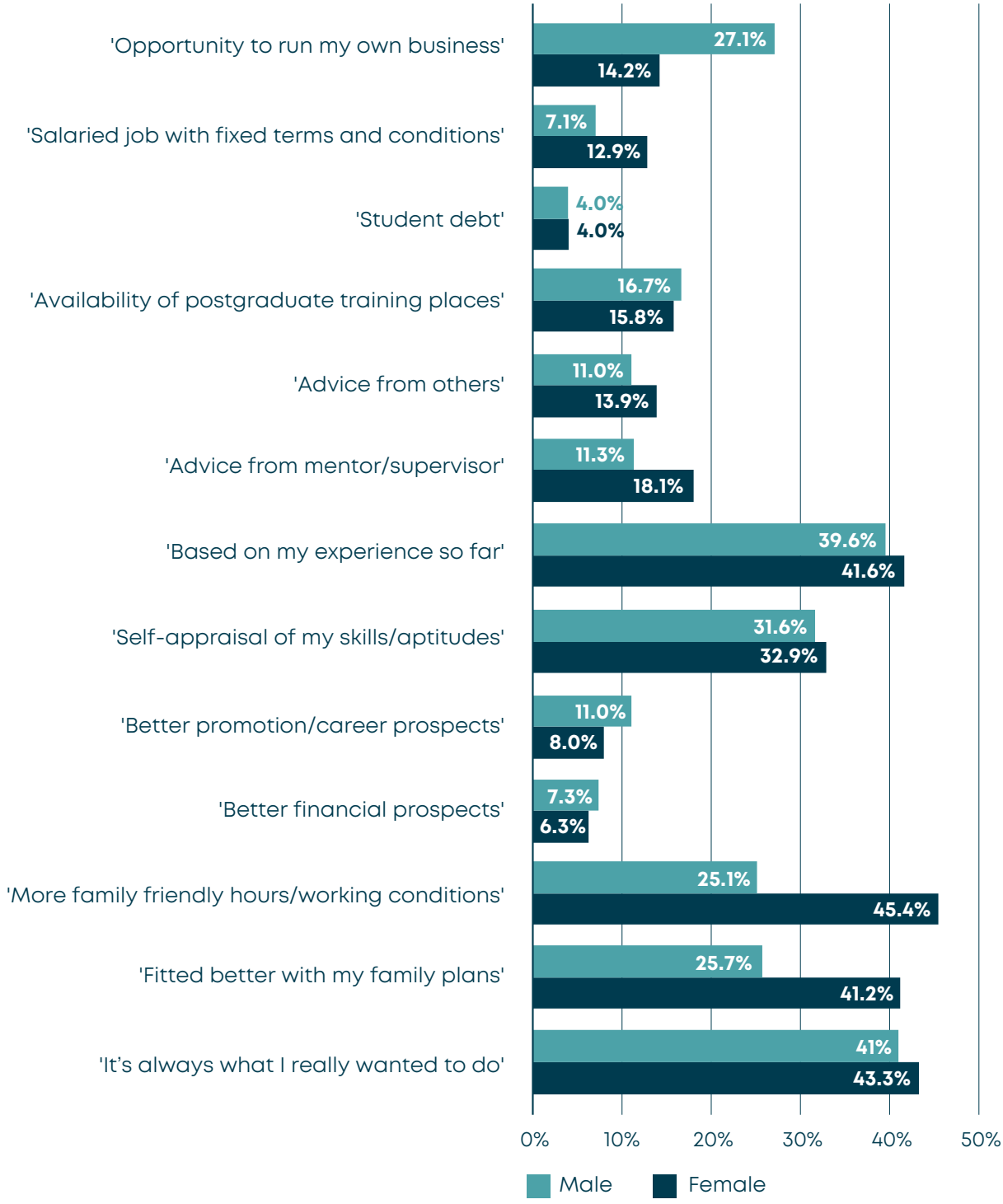
Figures from the HSE NDTP[14] show that:

- Over the last 5 years the gender breakdown in training has broadly been 56% female and 44% male, yet when we look at the gender breakdown in HSE consultant posts 60% are male and 40% are female.
- Throughout training, females tend to be over-represented in specialties such as Public Health, Obstetrics and Gynaecology, Paediatrics, Pathology and General Practice, and under-represented in Surgical Specialties, Emergency Medicine and Anaesthesiology.
- Across all disciplines the percentage of females employed as consultants within the HSE falls again.

Doctors were asked to indicate the factors that contributed to the choice of specialty. Factors that equally influenced both male and female doctors included, *'self-appraisal of their skills and attitudes, 'based on experience so far'* and *'it's what I always wanted to do'.* Female doctors, however, were strongly influenced by *'more family friendly hours/working conditions', 'better fit with family plans'* and *'a salaried job with fixed terms and conditions'.*

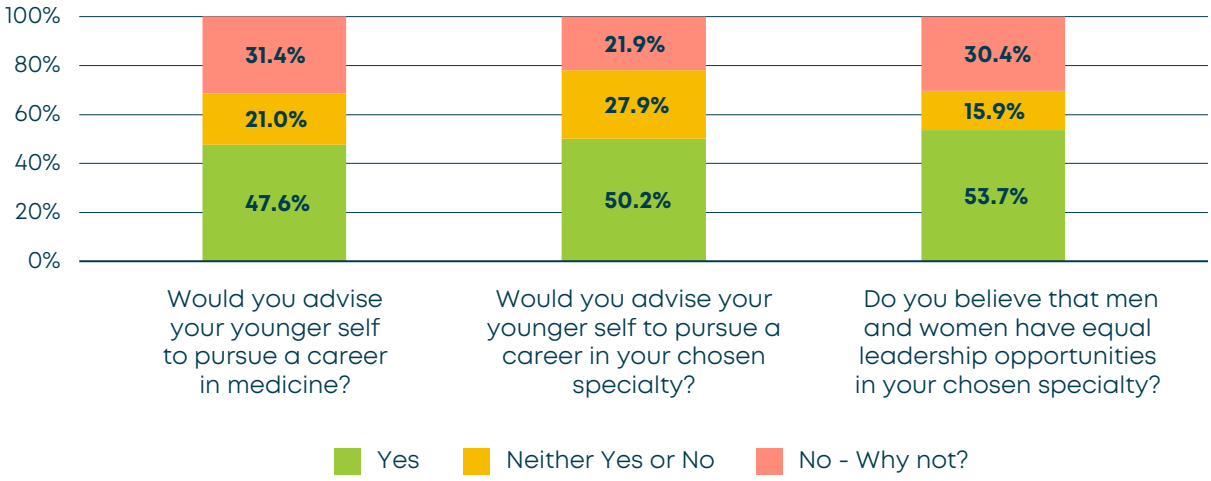
14 HSE - National Doctors Training & Planning, Medical Workforce Report 2021-2022 |

Factors that Strongly Influenced Choice of Speciality, by Gender



Other responses given in relation to factors that strongly influenced choice of speciality included *'less moving during training'*, *'accidental choice at a particular time in my life'*, and *'ability to have control of hours, location, type of work very important'*.

Reflections on Pursuing Medicine, Chosen Speciality, and Opportunites



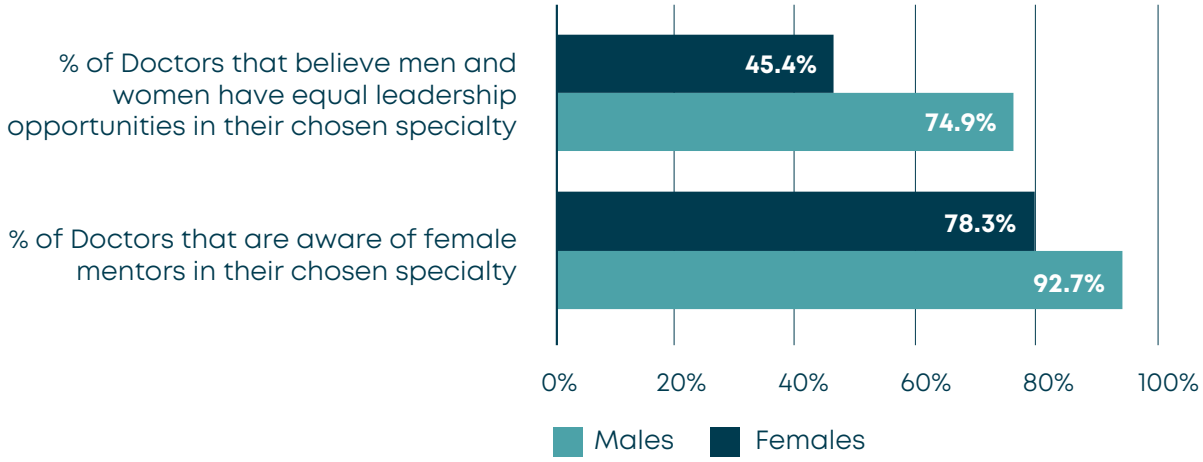
Reflections on Pursuing a Career in Medicine

In terms of reflecting on their decision to pursue a career in medicine or within their chosen specialty, 31.4% of doctors said they would not advise their younger self to pursue a career in medicine and 21.9% stated that they would not advise their younger self to pursue a career in their chosen speciality. Females (33.3%) were more likely not to advise their younger self to pursue a career in medicine, compared to males (27.1%) but there was little difference between males and females in relation to their chosen specialty.

Two accounts, who stated they would not advise their younger self to pursue medicine, reflect a dissatisfaction felt across doctors in the medical workforce:

- *No control over your own life, poor support, meagre and incorrect pay for hours worked, jumping through hoops to train, not feeling valued, professional apologiser for the state of the health system, no security in location of work.*
- *… it's always such a battle for annual leave or study leave. I spend so much of my own money & time trying to keep myself on par with my colleagues. I went into medicine as I like the thoughts of a mentally stimulating career and helping people. If I ever have children I will tell them to peruse a career in which your employer pays you respect and you have the potential for a work life balance. Outside of that you can volunteer to 'help people'. It's hard to keep giving to an organization that is unwilling to care.*

Doctors' Views on Leadership and Mentors, by Gender



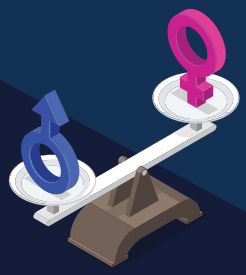
Leadership Opportunities

In terms of whether doctors believe that men and women have equal leadership opportunities in their chosen specialty, 53.7% said yes, 30.4% said no, 15.9% said neither yes or no.

In terms of a breakdown by gender, 45.4% of female doctors in comparison to 74.9% of male doctors believe that men and women have equal leadership opportunities in their chosen specialty.

Lastly, 82.3% said they aware of female mentors in their chosen specialty while 17.7% said they were not aware. By gender, 92.7% of male doctors are aware of female mentors in their chosen field, while only 78.3% of female doctors are aware of female mentors in their chosen field.

Group Specific Questions

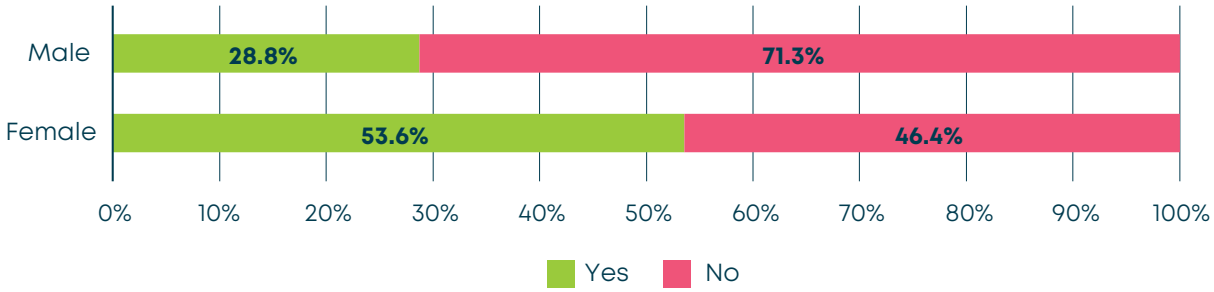


A number of specific questions in relation to were asked of certain groups, in relation to work-life balance, career choice and leadership opportunities.

NCHDs - Work/Family Life Balance and Career choice

NCHDs including interns and GP trainees were asked a number of questions in relation to their ability to balance work and family life during training.

NCHDs who have Postponed Having a Family for Fear of the Impact on Training Opportunities, by Gender



Almost half (48%) of NCHDs in training who responded have postponed having a family for fear of the impact on training opportunities. When disaggregated by gender, 53.6% of female and 28.8% of male doctors have postponed having a family for fear of the impact on training opportunities.

52 NCHDS in training who took maternity leave have had to either repeat all or part of a training post on account of their leave falling in the middle of a post. For over half (54.2%), the time they had to make up was not directly proportional.

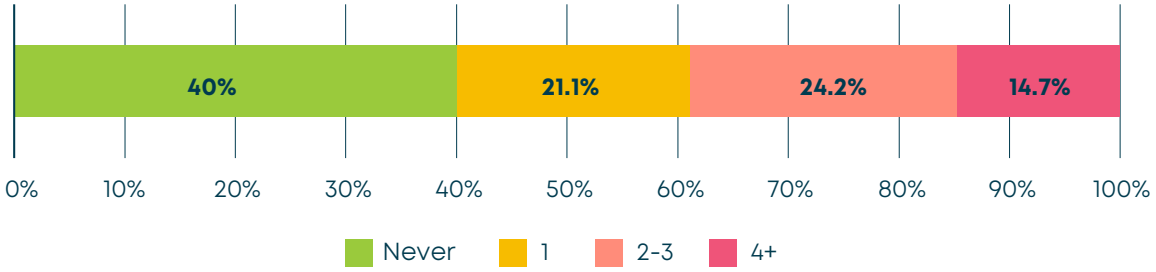
40%

of NCHDs in Training who applied for a flexible training post were unsuccessful

Just 32 (7.7%) of NCHDs in training have applied for a flexible training post. However, of this, just 6 in 10 of those who applied were successful granted a flexible training post, with 40% unsuccessful. Of those who were unsuccessful in their application some indicated that flexible training had been over-subscribed while others were not given a reason as to why their application was unsuccessful.

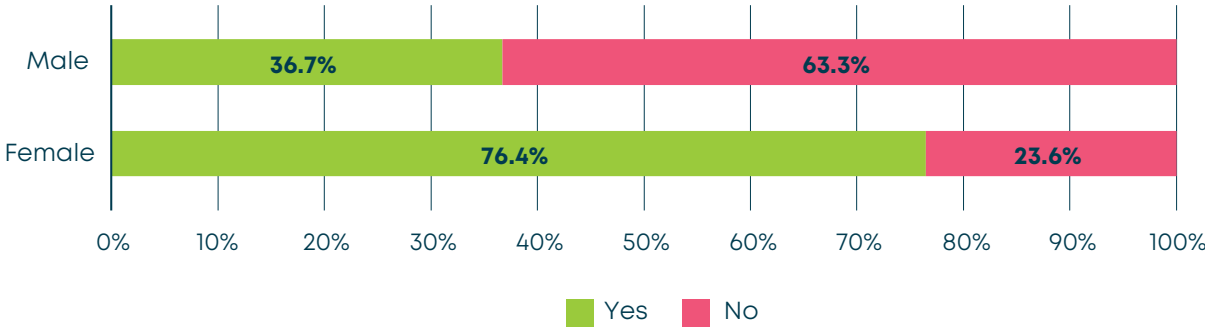
In terms of partner matching of posts, just 12 NCHDs (2.9%) have ever applied for partner matching of posts. However, of this only a third were successful in their application. 11 out of 20 qualitative responses stated that they were either unaware this was an option or felt it wasn't an option.

The Number of Times NCHDs in Training have had to change their Child's Surroundings (Creche/Childminder/School)



Relating to the imbalance and conflict between training and family responsibilities, 6 in 10 NCHDs in training have had to change their child's surroundings (creche/childminder/school) one or more times over the course of their training. 14.7% indicated that they had changed their child's surroundings more than 4 times.

% of NCHDs who have considered Changing their Career Speciality as their Current Working Conditions didn't seem Conducive to Caring for a Child, by Gender

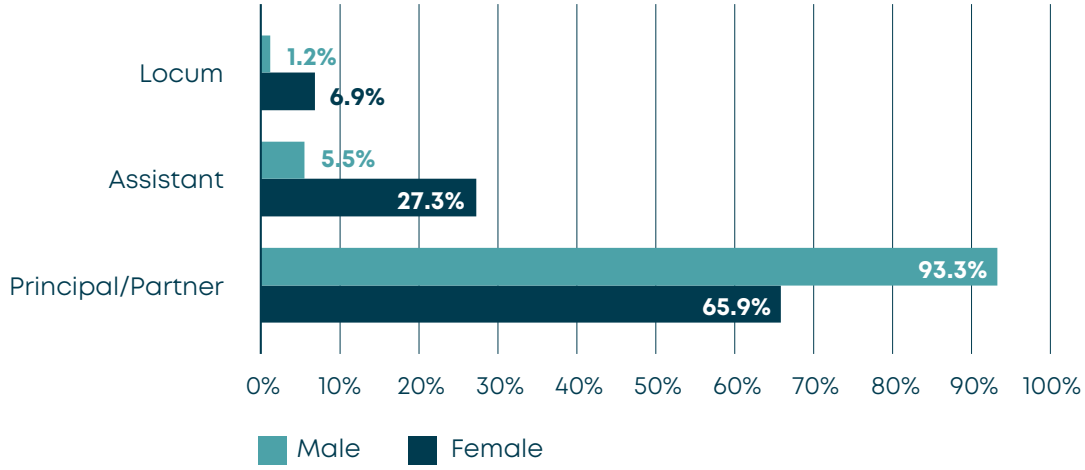


As a result of the above experiences, of those NCHDs in training with children, 69% have considered changing their career speciality as their current working conditions did not seem conducive to caring for a child, accounting for 76.4% of female and 36.7% of male NCHDs in training with children.

General Practitioners – Female GPs and GP Principal/Partner Roles

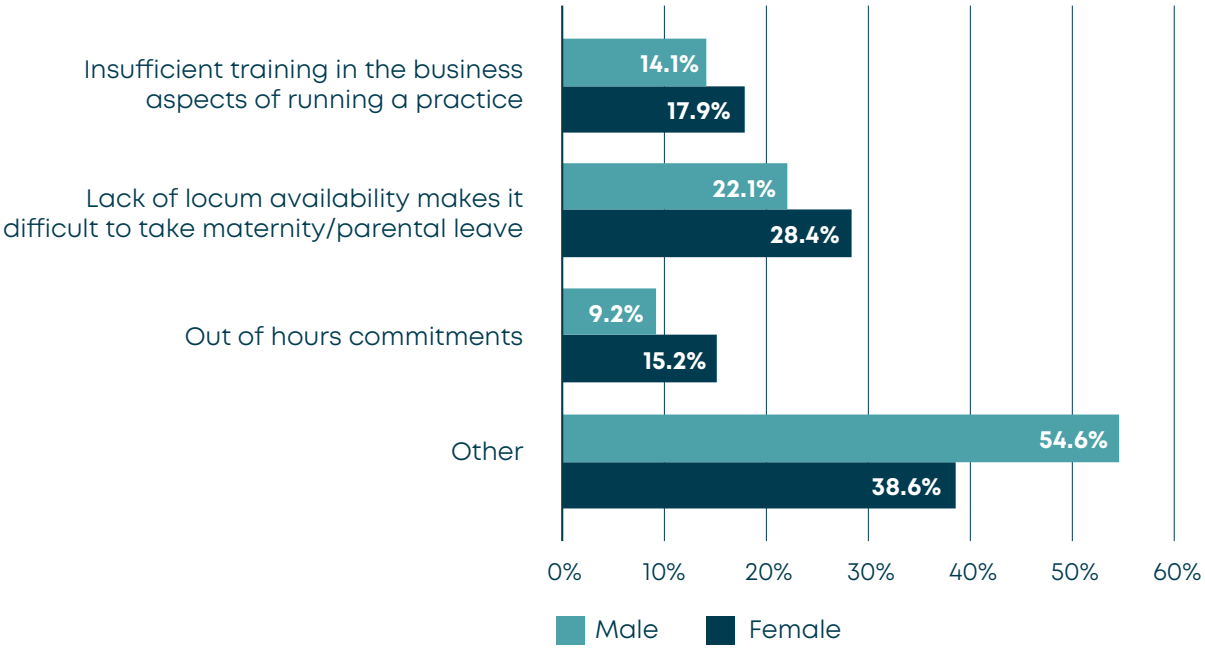
GPs were asked about their roles in general practice and the factors that deter them from taking up a principal/partner position.

GP Roles, by Gender



In terms of GP roles, 74.5% of GPs that responded to this section responded that they are GP Principals/Partners, 20.5% are Assistant GPs and 5% are Locums. However, 93.3% of male GPs are GP Principals/Partners compared with just 65.9% of female GPs. On the other hand, 27.3% of female GPs are GP assistants and 6.9% are employed as locums compared with just 5.5% of male GPs who are GP assistants and 1.2% who are employed as locums.

Deterrent Factors in Taking Up a Principal/Partner Position Within a Practice, by Gender



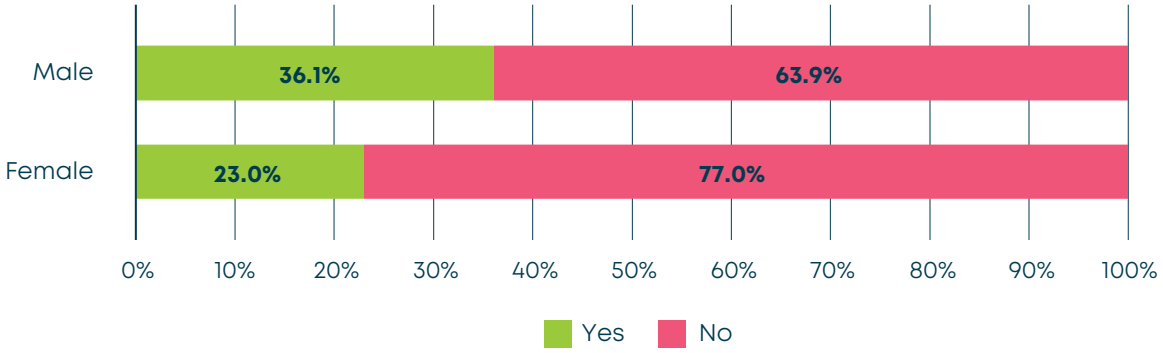
Multiple factors deterred doctors from taking up a principal/partner position within a practice. These include insufficient training in the business aspects of running a practice (16.6%), out of hours commitments (13.6%), lack of locum availability making it difficult to take maternity and parental leave (26.7%). There are differences in these regards, however, by gender.

Other deterring factors that doctors answered qualitatively include, *'lack of flexibility' 'significant full time commitment', 'childcare', 'out of hours cover and lack of locums very stressful', 'inequitable distribution of work' 'lack of opportunity' 'difficult to negotiate a partnership'* and *'financial viability'.*

Consultants and Leadership Roles

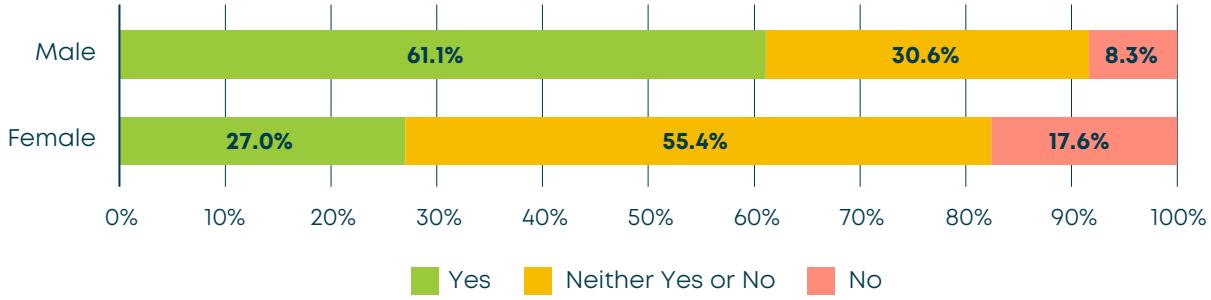
Consultants were asked a number of questions in relation to applying or being encouraged to apply for Clinical Lead or Director posts.

% of Consultants who have Applied for a Clinical Lead or Clinical Director Post



By gender, 36.1% of male and 23% of female consultants have applied for a clinical lead or clinical director post while 63.9% of male consultants and 77% of female consultants have not. Reasons cited for not doing so include *'too junior in career for now', 'time poor', 'too much added workload on top of existing clinical and admin. Would eat into precious family time and activities', and 'insufficient management support for the role'.*

% of Doctors who Think Women are Encouraged to Apply for a Clinical Lead or Clinical Director Post

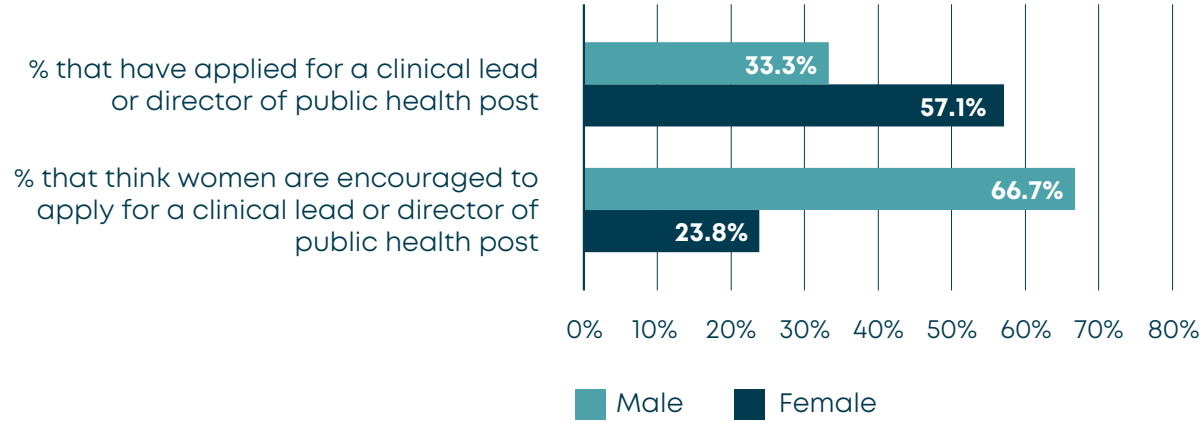


Asked if consultants felt women are encouraged to apply for a clinical lead or clinical director post, responses varied significantly by gender with 27% of female and 61.1% of male doctors of the view that women are encouraged to apply. Reasons given for this lack of encouragement, *'encouragement seems to be more directed towards male colleagues',* and *'there is a tendency by management to approach male consultants to help with tasks'.*

Public Health Doctors and Community Health Doctors – Leadership and Promotion

Similar questions in relation to leadership were asked of Public Health Doctors and of Career opportunities and pathways for Community health doctors.

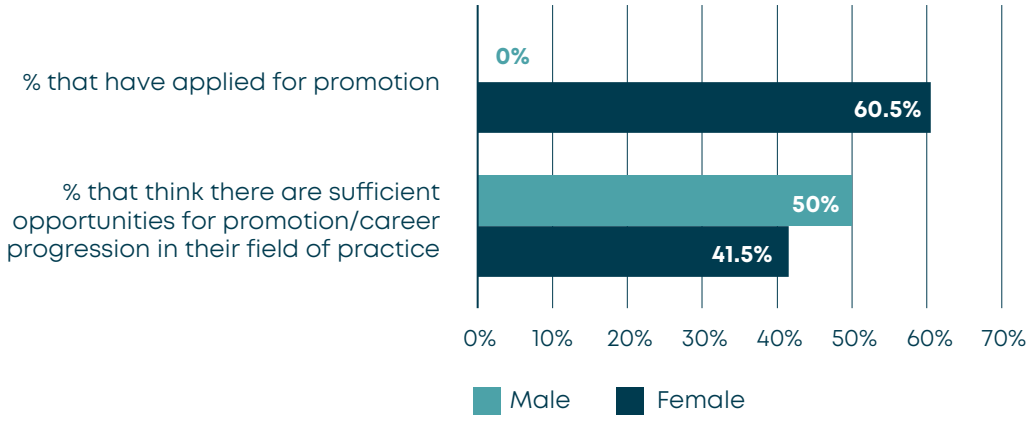
Public Health Career Opportunites



Over half (52%) of Public Health Doctors have applied for a clinical lead or director of public health post in this survey. For those who not done so, reasons given include *'can't take on additional responsibility due to family commitments'* and *'I have undertaken the role on a temporary basis and felt completely unsupported, with insufficient resources'.*

Asked where they think women are encouraged to apply for a clinical lead or director of public health post, 32% of respondents stated they are. By gender, 23.8% of female and 66.7% of male doctors think women are encouraged to apply. Reasons for the lack of encouragement include *'leadership positions are given to a select few who are tapped on the shoulder for the position',* and *'I was advised that a suitable candidate from the UK had made contact and I need not feel that I should apply.'*

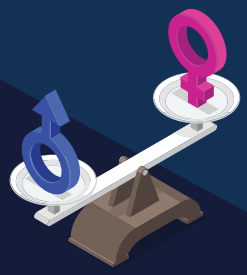
Community Health Career Opportunites



In relation to Community Health Doctors 53.5% indicated that they have applied for promotion. For those who have not done so, reasons include *'no promotional opportunities',* and *"I feel salary not representative of qualifications needed and responsibilities held by that post to wish to apply'.* 58% do not feel there are sufficient opportunities for promotion or career progression in their field of practice.

Similarly, when asked about whether women are encouraged to apply for promotion in their field of practice, 57% felt that they are not encouraged. By gender, 51% of female and 87.5% of males think women are encouraged to apply for promotion. Commonly cited reasons cited for a lack of encouragement for women to apply include a *'bias towards males for leadership positions'.* One respondent notes it is *'still a bit of a boys club and the lads are streamlined through training and lined up for certain opportunities'.*

Supports Required



All groups were asked about the types of supports required to better support women in medicine with a number of themes emerging. Of course gender equality is not just about supporting women and it was widely stated that any additional supports should apply to all genders.

More flexible Family Friendly Working arrangements

For all doctors more family friendly options for working were proposed including *'flexible working hours', 'part-time contracts' and options for 'job sharing'.* These included more flexible training posts and part-time options for consultants and *'Job sharing GMS lists'* for GP partners.

- *Better options to share GMS contract particularly at the start of careers (GP)*
- *Part-time Partnership Options (GP)*
- *Working around caring responsibilities. (Consultant)*
- *Allow for job sharing of such posts i.e., co-clinical lead, fit with many women doctors' lifestyles/work-life balance (Consultant)*

Better parental leave options for both parents

Many doctors, particularly NCHDS , advocated for *'better paternity leave and longer paternity leave to support new mothers'* and to create a more level playing field. It was also recognised that fathers also should have appropriate time off with their children.

- *Think better paternity leave would also help - not only is it important for our male colleagues but also helps level playing field. (NCHD)*
- *One of the main reasons we see less female consultants in more senior management roles or as professors is because too much of their energy and brain power has to go into looking after the kids and they are set back by the time spent on maternity leave, providing paternity leave of 6 months would shift this disadvantage away from just women and make it balanced across the sexes. It is important for fathers to get that time for their children as well. (NCHD)*

Better supports during pregnancy and breast feeding

A *'reduction in shift work during pregnancy'* and *'better breastfeeding infrastructure in hospitals'* were seen as options to support doctors, particularly NCHDs during pregnancy and breastfeeding.

- *Better regards for pregnant trainee's in terms of having to fulfil on call and shift work/ protection of pregnant NCHDs from night duty and being on-call. (NCHD)*
- *Reduction in shift work during pregnancy/ Pregnancy is vulnerable position. There needs to be more safety netting to support them feeling safe in working environment. (NCHD)*

More Accessible and Affordable Child care Options

More flexible *'childcare arrangements for shift working, night shifts, early starts and unpredictable finishing times',* and *'more affordable provision of childcare' including 'tax relief on childcare'* were proposed.

- *Working hours aren't compatible with childcare hours/ Flexible opening hours of creches. (NCHD)*
- *Childcare arrangements for shift working / night shifts / early starts /unpredictable finishing times. Issue for all male parents too. / If every hospital had 24-hour childcare on site, it would solve so many Issues, not just for doctors but for all hospital staff (NCHD)*

Addressing the Model of Post-graduate training

For NCHDs this also included addressing the model of training with 'more secure schemes and training posts' and ensuring that pregnant doctors are not penalised during training for taking maternity leave.

- *The current requirement to move around the country to work in different counties every year during HST is not conducive to family life and, in many specialties (such as my own, geriatric medicine) is unnecessary for training purposes. (NCHD)*
- *Regionalised training schemes- it is the most stressful part of my job, trying to maintain stability in my family even though the training scheme expects me to move from one side of the country to another every 6 months, then try to find childcare, GPs for my children, school places (in good schools), suitable housing for a family at a reasonable cost etc. My husband had to stop working outside of the home just to accommodate my moving every 6 months. It's ridiculous. (NCHD)*
- *I think that further discussion needs to be had with training bodies re the moving of trainees around the country and the detrimental effect this can have when family planning. (NCHD)*
- *More acceptability of flexible working hours during training and opportunities to work from home. The necessity to move geographically during training is a huge deterrent for anyone with family. (SMO)*
- *Ensuring maternity leave does not impact on pay scale and regular progression is honoured. (NCHD)*
- *Make up only for time lost during maternity/ proportional time to be repeated if off on maternity leave during training. (NCHD)*

Addressing staff shortages

For many staffing shortages and access to locums was seen as a barrier preventing doctors from taking their full maternity and parental leave entitlements. This was particularly an issue for GPs where the responsibility lies with the individual to source locums.

- *Ultimately the issue is that of service provision in a chronically underserviced system. I think having better staffed teams would allow females colleagues (and male colleagues with paternity leave) to take their maternal leave and for both have a better work-life balance in relation to family planning and care. (NCHD)*
- *Full cover for leave (HSE to establish panel of doctors to cover for doctors in case of illness/maternity /paternity leave - the stress involved in finding locum as well as the woefully inadequate funding provided by the GMS contract for leave is a major problem) , more flexible attitudes to time off for family commitments. (GP)*
- *I think better availability of Locums in order that we can take statutory amount of leave. GPs often end up working continuously in order to keep practice open and patients safe (GP)*
- *Locums! Plus, it's hard enough to find one doctor, but to enable flexible working hours during the week you'd need more than the bare minimum-working outside of the major cities means you're always at pains to find people to hire. More grants towards hiring support staff would help. (GP)*

Less Onerous Workload

Staffing shortages, excessive workload and inability to balance work and family commitments were issues that deterred many doctors from taking up leadership or partnership roles. For consultants and specialists in public health, proper backfilling of roles would encourage doctors to take up leadership posts , while for GPs, addressing issues such as out -of-hours demands would encourage more doctors into partnership roles.

- *…Leadership roles often mean adding this work to existing clinical workload. …Having a definite consultant cover or backfill for one's clinical commitments so that one would have dedicated time for one's clinical lead role. In other words, more women including myself might consider a leadership role if there was a clear commitment to supporting the individual in that role. (Consultant)*

- *I think more MDT team supports and administrative supports are required for all in leadership positions in Public Health Medicine. These positions are very onerous. The majority of leadership positions (e.g., DPH) are occupied by women at present. But it's still possible that males are disproportionately represented in senior leadership although males are in the overall minority. I think the lack of practical supports are a big issue and make many leadership posts unattractive, particularly those requiring constant OOH availability. (SMO)*
- *It's not just a female issue, it's an issue for all GPs. There aren't enough of us, the demands of the job are increasing. We can't find people willing to work the hours required to run a service. This effects our patients and us. It's not a gender issue. (GP)*
- *Onerous out of hours needs to be changed as it is not compatible with family life. Workload too high for GPs, I work 2 days, but each day is 11 hours long, without a supportive partner who helps with childcare I couldn't do it at all. (GP)*

More leadership Opportunities and Supports

Better opportunities and supports were also seen as necessary to support women in leadership or practice partnership roles.

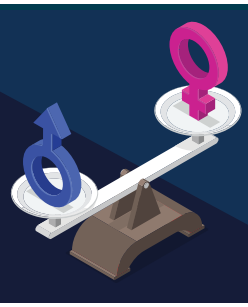
- *there aren't many leadership roles available. Hopefully, that will change in the coming years. Opportunities in public health are not equally available to all. A lot of projects etc. tend to be word of mouth, so people don't get the chance to get experience in various areas, including leadership roles' (Public Health Specialist)*
- *Part-time partnership availability. Practice management training. More willingness of existing GPs to take on a partner with clearer pathways to partnership. Mentoring and guidance on entering a partnership and setting up a practice and more supports to enable sourcing Locum cover staff etc. (GP)*
- *To start my "organic change" would require some mentoring of the likely leaders from those who have come before them. A formal mentor programme to teach the additional skill required to lead would help. (Consultant)*

Cultural Change

A cultural change was also repeatedly cited as an important step for women to be encouraged, with *'less misogyny among senior colleagues and HSE management', 'less of old boy clique attitude',* and *'less discriminatory attitude'* quoted by consultants, in particular as needed. Proposed solutions included education and training in gender equality and unconscious bias as well as better policies for reporting bullying and harassment.

- *'Education on gender equality and sexual harassment should be a mandatory module for all doctors, regardless of gender, age or grade'. (NCHD)*
- *'Unconscious bias training for interviewers and evaluators' (NCHD)*
- *'Protected pathways to report bullying and sexual harassment' (NCHD)*

Conclusion



The results of this survey show that female experiences of a career in medicine can vary significantly from their male counterparts. While many of the issues affected both sexes, females are often disproportionately affected.

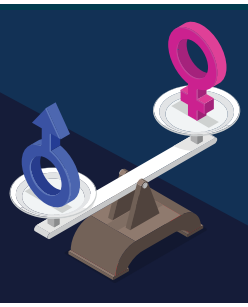
For women, balancing work and family commitments can impact on earnings and specialty choice. In relation to taking parental leave and childcare, females are more likely to take unpaid parental leave or to reduce their hours in order to care for dependents than their male counterparts while female doctors requiring childcare are more likely to have higher childcare costs and experience difficulties in accessing suitable childcare. Indeed in addition the ability to balance work and family has a significantly higher impact on females doctors' career choices right through from training and their choice of specialty through to their decisions to take up clinical leadership roles or principal/partner positions in practice.

And for three-quarters of all doctors, the culture of bullying, harassment and gender discrimination in medicine is a serious issues with female doctors more likely to experience harassment and discrimination in the workplace than males.

There are significant differences in opinion between male and female doctors in relation to the existence of gender pay gap in medicine and the factors that contribute to it. There are also significant differences in views between genders in relation to opportunities for leadership in their specialty and the supports available.

The findings of this report indicate the need for more family friendly policies in the workplace particularly, and the need for a cultural shift in medicine in relation to bullying, harassment and discrimination. In particular, the model of post-graduate medical training in Ireland is outdated and is not conducive to supporting an appropriate work-life balance for young doctors, many of whom may be considering to start or have already a family.

IMO Recommendations



Family Friendly Work Options

In order to create a better gender balance in medicine , family friendly policies are required across the HSE including:

- more flexible options for working across the HSE including options for part-time working and job sharing;
- appropriate staffing levels/locum cover to allow parents take their full entitlements to maternity and parental leave;
- flexible and affordable childcare options on site in line with working hours;
- support doctors in returning to the medical council register after taking career breaks.

Ensure all doctors are aware of their Parental Rights in Relation to:

- Pregnancy and maternity leave;
- Health and safety during pregnancy;
- Appropriate lactation facilities and breaks for breastfeeding in line with the HSE breast feeding policy;
- Parental leave options for both parents.

Modernise the Model of Medical Training

The model of medical training is in urgent need of reform and modernisation to meet the requirements of young medical professionals including:

- Greater predictability of location of rotations;
- More flexible training options and the possibility of partner matching;
- Compliance with EWTD so that NCHDs are assured a proper work-life balance;
- More flexible and consistent working hours;
- More fellowship opportunities at home;
- Ensure time made up for maternity or other parental leave is proportional.

Promoting Female Leadership in Medicine

In order to encourage more females into leadership roles within our health services, action by the HSE and post-graduate training colleges is needed to:

- Promote female role models and mentoring;
- Provide leadership training both at postgraduate and as part of continuing professional development;
- Assure the proper back filling of clinical duties;
- Provide clear pathways to career progression.

In order to encourage more women to take up GP principal positions we need to make General Practice more family friendly with

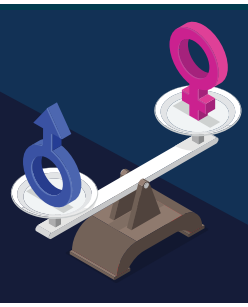
- Less onerous out of hours requirements;
- Better locum availability so that all GPs can take proper breaks;
- Options for less than full-time working/job sharing;
- Training in practice management and partnership negotiation.

Cultural Change

In order to address the culture of bullying and discrimination in medicine

- Education and training in medicine and in management in gender equality issues including addressing unconscious bias;
- Ensure mechanisms for reporting and addressing bullying and harassment and discrimination in the workplace are fit for purpose.

Sources



BMA, 2021 , Sexism in Medicine Report 2021, BMA London, UK https://www.bma.org.uk/media/4487/sexism-in-medicine-bma-report.pdf

IMO 2017, IMO Position Paper Women in Medicine, Dublin https://www.imo.ie/policy-international-affair/documents/IMO-Position-Paper-on-Women-in-Medicine-Final.pdf

Lewiss, R.E., et al.,2020. Is academic medicine making mid-career women physicians invisible?. Journal of Women's Health, 29(2), pp.187-192. https://www.liebertpub.com/doi/full/10.1089/jwh.2019.7732

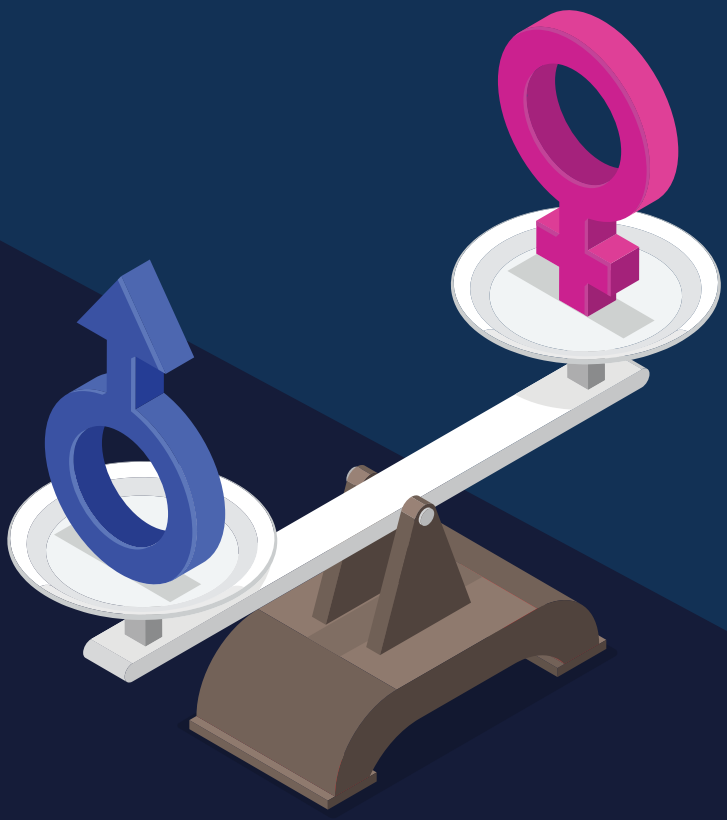
Merritt Hawkins 2019 Survey of Women in Medicine: Gender-Based Pay Disparities and Workplace Discrimination, Dallas, Texas, https://www.merritthawkins.com/uploadedFiles/Merritt_Hawkins_2019_Women_In_Medicine_Survey.pdf

Rich A, Viney R, Needleman S, et al. 2016 'You can't be a person and a doctor': the work–life balance of doctors in training—a qualitative study. BMJ Open 2016;6:e013897. https://bmjopen.bmj.com/content/bmjopen/6/12/e013897.full.pdf

Shannon, G., Jansen, M., Williams, K., Cáceres, C., Motta, A., Odhiambo, A., Eleveld, A. and Mannell, J., 2019. Gender equality in science, medicine, and global health: where are we at and why does it matter?. The Lancet, 393(10171), pp.560-569. https://www.sciencedirect.com/science/article/pii/S0140673618331350

Smith F, Lambert TW and Goldacre MJ, 2015, Factors influencing junior doctors' choices of future specialty: trends over time and demographics based on results from UK national surveys Journal of the Royal Society of Medicine; 2015, Vol. 108(10) 396–405. DOI: 10.1177/0141076815599674

WMA 2018, WMA Statement on Gender Equality in Medicine¸ Reykjavik, Iceland, October 2018 https://www.wma.net/policies-post/wma-statement-on-gender-equality-in-medicine/



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