

Women in Academic Medicine: Challenges and Issues

A Report by Health Policy and Economic Research Unit

September 2004



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A Report written by the Health Policy and Economic Research Unit at the request of the Medical Academic Staff Committee

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Summary

The BMA is keen to address the under-representation of women in the medical academic workforce and is undertaking research in this area in an attempt to gain a better understanding of the issues. In order to explore the challenges and issues facing women in academic medicine in some depth, two focus groups were held. This report summarises the key issues raised by participants involved in the focus group discussions.

Many of the issues raised in the focus groups were gender specific and include:

- Many women in the focus groups did not adhere to a mainstream career route for a variety of reasons. The unconventional career progression experienced by many women should be recognised as an advantage and serves to illustrate the level of dedication and motivation displayed by women in the pursuit of an academic career.
- Age was felt to be a key factor in the career progression of women, particularly when competing for senior positions.
- It was generally agreed that women and men have different skills and approaches to an academic career. It was suggested that these differences require greater acceptance and recognition.
- Networking and raising one's profile are perceived as being skills which are particularly difficult for many women in the context of academic medicine.
- A further difficulty which faces many women is re-entering the workforce after taking a career break for caring commitments. Measures of academic success, such as the RAE, do not take such career breaks into account, and hence women are further disadvantaged by 'obvious gaps' in their CVs.
- A definite 'glass ceiling' to senior posts and higher level positions in academic medicine for women was identified and it was suggested that university departments must be made more accountable, particularly in relation to senior appointments.
- There was overwhelming agreement regarding the importance and value of mentoring and role models for women working in academic medicine.

Further issues raised were gender independent but specific to academic medicine:

- There is a need for a more structured career path into academic medicine, with both clinical and academic commitments recognised. As part of the academic component, greater recognition needs to be given to teaching.
- Many participants argue that part-time working is not taken seriously, and that it is virtually impossible given the demands of an academic medical career. The pressures and expectations of an academic research career, often combined with clinical commitments, means that part-time working is extremely difficult.
- Current job expectations of a medical academic position are unrealistic and unreasonable. The importance of reasonable expectations is highlighted, particularly in relation to the RAE, which does little to take into account part-time working.

Introduction

The BMA's Medical Academic Staff Committee (MASC) is working to promote the recruitment and retention of clinical academic staff, and particularly, engaging women with academic medicine. Currently, academic medicine is failing to attract and retain women. Women are currently under-represented as clinical researchers, full-time academics and heads of departments, yet a growing proportion of the medical workforce. The BMA is keen to address this under-representation of women in the medical academic workforce and is undertaking research in this area in an attempt to better understand the issues. The aim of the research is to identify both barriers that exist and good practice in pursuing a medical academic career.

Method

In order to explore the challenges and issues facing women in academic medicine in some depth, two focus groups were held during July 2004. An invitation to attend the focus groups was sent to a random sample of women working in a medical academic position, ranging from junior researchers to professors. Both of the focus groups were held in London, which may have biased the origin of participants towards those based in London and the South East. Nonetheless, participants from across the United Kingdom were in attendance (see appendix 1). A total of 26 women engaged in a range of academic medical activities attended the focus groups. This report summarises the key issues raised by participants involved in the focus group discussions and illustrates these issues with verbatim comments, where possible.

Issues facing women in academic medicine

Participants in both focus groups were asked to discuss their experiences and concerns regarding women working in academic medicine. A range of concerns were raised from the outset. Whilst many issues were gender related, others were non-gender specific, but related specifically to academic medicine. The following comments reflect these perceptions:

'I guess you're reluctant to accept that ... it almost seems like an excuse saying that it's anything to do with your gender, but actually if I think about it, I mean there are a lot of issues there. I thought it was just me not being very good.'

'There's always this tension I think in academic medicine between people wanting you to be a clinician and being academic, and to try and do both is getting increasingly hard.'

Several of the participants commented that they had been reluctant in the past to participate in forums discussing gender-related problems in the workplace, as the issues have often focused on family commitments and childcare issues. Several participants suggested that the problems and concerns facing women in academic medicine are not always related to having children and family commitments and welcomed the opportunity to discuss these in more depth.

'But I've always shied massively away from any women's forums about anything, because I don't have children, and so many of the women in science issues are around children and families, so I've always thought that those aren't my issues. But now I'm starting to realise there are actually another set of issues which are you don't have to have children to be having problems'.

'Until recently I've always felt that BMA's women's issues have been about childcare and, as I don't have children, I felt that I haven't really had my female views represented, so I'm really glad that we're talking about issues that go beyond childcare, as well as childcare'.

A range of challenges facing clinical academic women were identified in the focus group discussions. Other issues raised were gender independent, but specific to academic medicine. The key issues are now summarised and illustrated by verbatim comments where possible.

Unorthodox career progression

From the outset, participants recognised the unorthodox and 'often tortuous' routes taken by many women into an academic medical career. Many women in the focus groups did not adhere to a mainstream career route for a variety of reasons, and felt that this was viewed negatively by male colleagues, who often took a more traditional, direct career route. It was suggested that instead of being seen as 'threatening the mainstream', the unconventional career progression experienced by many women should be recognised as an advantage and serves to illustrate the level of dedication and motivation displayed by women in the pursuit of an academic career.

'I feel that because women have got other responsibilities, their career always, in the majority, are more tortuous than men. I think there will be men who change specialties because of the need of the child or the family or for other reasons, but somehow I feel that women are much more... among women you will find much more concentration of this type of career, which is not straightforward. They come into their final specialty through very tortuous routes and because you are outside the system, men in positions of power to help you cannot, because you are coming from outside, not within the mainstream'.

'When you say that we come from an unconventional background, we actually threaten the orthodoxy, that's the whole point I think, and it may not be simply that they (men) cannot help us, it may be that it actually threatens their position... it threatens the whole way they establish themselves, and I think that it's very difficult to actually identify it'.

'Most women have a tortuous career path, they come from a different angle, it's not the mainstream, it's looked at as a handicap instead of being looked at as an advantage, because these people have got so much commitment that they went through all these hurdles to do what others are doing as a straight line. Why people can't see that this is an advantage, these women are so motivated to keep going, despite all the obstacles they keep going, they never give up.'

Age

Several participants were of the opinion that age is a key factor in the career progression of women. Many suggested that academic competition, particularly for senior positions, is in many cases hindered by age. This problem was seen as one which particularly affects women, as many have taken longer, less direct routes into their career and are often older than male colleagues in similar positions, as a result.

'I've never thought of it as a gender issue, but it may be is. I'm considered a bit old, because I'm 39, and I've had people coming through getting offered fellowships and senior lectureships at 32, 33, because I sort of took my time.'

'I was told quite explicitly that over the last couple of years I've done much better and really quite well, but it's a bit late because I should've done it five years ago, which is why I'm suddenly feeling terribly old at 37, which I know isn't old. And I haven't had time out to have kids or anything.'

Skills and values

It was generally agreed among the participants that women and men have different skills and approaches to an academic career. Men are perceived to be more career orientated, ambitious and able to 'negotiate the system', whilst women are less assertive, lateral thinkers. Some participants suggested that on the whole, women have better communication skills and are able to juggle more tasks and responsibilities than their male colleagues. However, the ability to multi-task is often perceived as being a disadvantage for women, as it detracts from a clear and direct career path. Whilst adjectives such as 'nice', 'accommodating' and 'sensitive' were used in the group to describe women, 'empire-building', 'aggressive' and 'focused' were used to describe males in this context. Furthermore, where women are seen to be more assertive and career-minded, they are often described as 'scary', whilst 'focused' denotes the same qualities in a man. These perceptions impact significantly on the progression of women in academic medicine.

Whilst it is recognised that academic medicine is a male-dominated environment and success is largely based on male standards, the question was raised by focus group participants,...'Why should women have to act like men to be successful?' Instead, participants suggested that the differences in the way men and women work requires greater acceptance and recognition.

'I do think that men have a much more career orientated mind and they see the end already right from the beginning, whereas women tend to meander a bit and "Oh I enjoy this, so that's fine...". Whereas men just have this focus going in a straight line.' 'I think there are fundamental differences, although there is obviously an overlap in personality traits between males and females. From my experience, in a very male dominated specialty, they (men) are narrow minded and therefore it's easier just to pursue what they're following, because they're unaware of other people's feelings to a certain extent and can be more focused. And I think with that then comes a confidence and sometimes I don't know if it's just natural confidence or whether it's an ego that has to be maintained, but as a result of that it makes it easier to achieve your goal because that's what you're going for'.

'It's also a disadvantage being a multi-tasking type personality, because it means you start to take on things that are peripheral to your central research. And I think that's what men don't do, because of this focus. So women tend to do a bit of this, do a bit of that, and then this is interesting so I'll just whoomph over here, round the corner and do that as well. And I think then that actually just detracts from the straight line, which is actually the career path in medicine'.

'I think there is a difference between the way men work and think and the way women work and think, and I don't think that that can change. I mean there are obviously some women who think like men, Mrs Thatcher being the best example'.

'And let's face it, so it's easier to put obstacles in the way of a woman compared to a man, because we are less assertive in general. And I discovered, being nice and polite, it's interpreted as weakness. You have to show aggressiveness every now and then, unfortunately, which means really being trained to do that'.

Networking

One of the recognised barriers to the career progression of women in academic medicine is not knowing or being able to approach the 'right people'¹. Networking and raising one's profile are perceived as being skills which are particularly difficult for many women in the context of academic medicine. It is suggested that women are often not as visible as their male colleagues at conferences or meetings and that this is due to the lack of assertiveness of many women and the negative perception of women who do take the lead in their field. Assertiveness among women is often interpreted as being 'pushy' and several participants express apprehension and unwillingness to take on this role. The largely male-dominated nature of many of these events further deters many women from pursuing this role.

'I've just been to an international meeting and of 64 oral presentations, only eight were made by women, and of the invited ones, which was about half of those talks, only one was a woman who'd been invited. And it was an area where people are discovering new genes for things and the genes had been discovered by women, who'd written papers, but they weren't being asked to talk about it because they weren't, I guess, the 'right' people'.

'In my experience a lot of networking takes place at conferences, normally in the small hours in the hotel bar or what have you.... men are sort of encouraged to go up and network and all the rest of it, and that's the done thing. And I think sometimes as a woman if you do that you'd probably be considered as quite pushy or whatever'.

'My male boss has certainly introduced me to the key names in the field when we've been at conference together, but if we're not together then my inclination to go forward is very reduced. The other thing is that, talking about pushing forward to present at conferences, I think it's not just about being invited, I've also wondered whether it's women not pushing forward to say, when you tick the boxes on the conference application form, I always go 'poster', I never say 'or oral if you want me', it's just like I don't do that, and I don't know whether that's a male/female thing, but I suspect partly it might be'.

'Maybe because when you have a group of males standing together talking and you have to walk into that arena it's much easier if there was another woman there, because, I don't know, I think I would feel much more comfortable walking in if there was one other woman. I know it has always helped if there was one other woman there'.

¹ Blake, M and La Valle, I, 2000. *Who applies for Research Funding?-key factors shaping funding application behaviour among men and women in British higher education institutions*. London: National Centre for Social Research

Part-time working

Increasingly, the evidence suggests that doctors would like to work less than full-time. Recent research suggests that whilst one in four doctors are either currently working less than full-time or would like to do so in the future, there is a distinct variation according to gender, with the vast majority (93%) of female doctors wishing to do so, compared with males (46%)². The key message voiced by many of the participants regarding part-time working is that not only is it not taken seriously, but it is virtually impossible given the demands of an academic medical career. Increasingly, many medical academics, largely women but not exclusively, are unable or unwilling to work on a full-time basis for a range of reasons. However, the demands of a medical academic job mean that part-time working often means 'full-time hours but part-time pay'. Some participants suggest that the pressures and expectations of an academic research career, often combined with clinical commitments, means that part-time working is extremely difficult, if not impossible.

'Being assertive is related to working part-time, because I think if I look back I probably almost felt that I had to apologise that I'm not there full-time and therefore I had to accept things that I probably certainly wouldn't have accepted had I stayed on working full-time, because I almost got to be grateful for the fact that I have been able to work part-time.'

'Despite having published quite a lot and got quite a few grants under my belt, I was told that I would never compete with full-time researchers.'

'My male colleagues could work all the hours they want, which include travelling to other towns while we're doing projects and supervising things. Even on the three days I worked I found it a lot more difficult, with family commitments, to actually... it takes a lot more effort for me to be able to arrange travel and to do these things, so even on those three days I don't feel I can ever compete on equal terms. And I don't think I particularly mind that, as long as I'm assessed on the amount I work. It's quite interesting actually... quite a few of the people at work almost behave as though I work full-time, even though I've been working part-time for six or seven years.'

'But there aren't any part-time academic expectations because basically you've got to get your publications in the 'right' journals, that's what you're judged on, you're judged on your grants and your papers, and that's not a part-time process. So even if you go part-time, you'll be working 80 hours a week, because otherwise you're not going to compete.'

²Health Policy and Economic Research Unit, 2004, *BMA Cohort Study of 1995 Medical Graduates-Ninth Report*, London: British Medical Association.

'I was actually working part-time at one stage when my kids were younger, and pressure was put on me, they said "You must go full-time, you will not be taken seriously unless you do"... But that was actually said, "Don't work part-time".'

'On the whole women will have families, will have kids. It's like my husband, it's alright for him to stay at work until 10, 11 o'clock, but for me, come 5 o'clock, it's like, Oh my God, I want to go home and see my child otherwise I'm never going to see anybody. But I've got loads of work and I would love to stay there until 10 o'clock at night and carry on with my research, but I can't. And I think that women have to juggle many more things. I think the other thing about women is that maybe there is a general tendency to help out.'

'Academic medicine is fantastically hard work, you cannot do it part-time, even if you are in fact contracted and paid to do it part-time, because apart from anything else, it's not just that you've got to produce the same number of papers, but if the Lancet's published on a Friday and you don't work a Friday, you still have to write the critical paper by Monday morning when someone says "Have you read this?" when you're sitting in some meeting. So the reality is that research is continuous, it is 24 hours/7 days, and that's all there is to.'

Career progression

A definite 'glass ceiling' to senior posts and higher level positions in academic medicine for women was identified by many participants. Although this was interpreted largely as gender discrimination, it was also recognised that a gradual change in the culture was occurring, with more women moving into more senior posts. It was suggested that university departments must be made more accountable, particularly in relation to senior appointments. The lack of available senior posts within universities was also seen to be exacerbating this problem.

'There should be people championing the cause of senior lecturers in general and academic medicine, but specifically for women. Checks on whether it is only because of behaviours within departments that these women are not getting a break should be made. I mean obstacles put in their way, how can we support them? We need support at a higher level in the university for this to happen.'

'As a junior, I'm very aware of the glass ceiling for women, and where I work a few women are getting through. We have quite an active male professor pushing women through now, but we don't have enough women at the top to mentor.'

'I was immediately given an honorary consultant post, but the head of department wouldn't let me go on to a consultant scale, and I didn't go on to a consultant scale until very recently, although I have been a consultant for a long time. There are absolutely masses of stories of people that were not hitting the senior targets... there are other women who have left because they should've got chairs and they didn't'.

'But I wonder if there is something about competitiveness. I was definitely raised up by men and it very definitely was men that picked me up and said to me "This is where you should go" and it was fantastic. But, when you get to actually maybe competing with them on an equal level, that's I think where there probably is some active negative work. They're very happy to raise you up, and also actually that reflects on them, they get someone who gets a fellowship. But when it's actually competing at maybe the level of chair, I just wonder if that's where there is actually some active "Well, you know it's going to be the person I talk about football to all the time that I meet in the bar or that I meet in conferences" which we don't go to because of kids or whatever'.

'What I would like to see coming out of this, is this emphasis on the senior posts, because there aren't that many for people to see. Everyone's discussed how few women there are at the very senior level. I think if people look around and look up they don't see somewhere to go and they don't see those posts being filled or even being there'.

Mobility between jobs is often seen as a positive step in academic career progression, as it is perceived as broadening one's experience. However, in many cases women are less flexible than men in terms of mobility and men are generally more able to move for jobs. As the following participant suggests:

'...it's going to be far more that the man moves for a job and that the woman follows, rather than the woman moves for a job and the man follows. If the children are at school, the woman's not going to move them and all that. So I think women have less flexibility about moving from job to job, and because the research career is very insecure and you tend to be potentially moving all the time, that is less conducive then to women.

Research Assessment Exercise

Evidence suggests that a higher proportion of men than women were counted as research active in the 2001 Research Assessment Exercise (RAE) in the UK and in proportional terms, males were 1.9 times more likely to be counted as research active³. One aspect of academic medicine which caused concern for many participants is gaining recognition for publications and many felt that there was discrimination against them as women, both directly and indirectly. A number of issues raised by the participants worked to further compound their lack of RAE competitiveness: career breaks, family commitments, teaching commitments and a greater inclination toward multi-tasking compared with their male colleagues. In some cases, an extensive publication record was unlikely to be rated highly in RAE terms, due to the lack of first authored papers. In other cases, career breaks and flexible or part-time working meant that many women were not seen to be as research active as their male colleagues. The following comments illustrate these concerns:

'I have a reasonable number of second and third author papers, because I was terribly good at joining in other people's projects and collecting data for my boss, and have now been told that really I only have one paper, because there's only one that's mine, even though my CV is a reasonable length. But that's probably specific to me, rather than to being a woman, but it may be that it's more of a female way of behaving. I've done lots and lots of teaching, lots and lots of work and it doesn't show on my CV and I'm having trouble getting a job'.

'I cannot get the first authored publications, because my boss is always first author on my studies. And I suppose when this started, and the trouble is I let it happen, and so when it started, a) I was grateful and b) I suppose also I've never been a particularly empire-building sort of person, so I just thought who cares? But of course, you come to realise that this actually isn't such a brilliant idea, because I'm not feeling valued and I'm always being the second author, and it's quite difficult to see how to break through that barrier'.

'My background is full of letting other people do things because you think you're not up to scratch. Maybe it's a female characteristic rather than something that society has against us, it is a way of behaving that maybe is female'.

³Association of University Teachers, 2004, *UK Academic Staff 2002-3: Gender and research activity in the 2001 RAE*. London.

Career breaks

A further difficulty which faces many women is re-entering the workforce after taking a career break, often to have children or for family commitments. Although this problem is not unique to an academic environment, nor is it a solely feminine problem, women are more likely to take career breaks, particularly in the form of maternity leave. Measures of academic success, such as the RAE, do not take career breaks into account, and hence women are further disadvantaged by 'obvious gaps' in their CVs. Several participants applauded retraining schemes which provide support, encouragement and development for re-entry after career breaks and emphasise the need for such schemes.

'The impact of maternity leave on the number of papers, there's a gap, and of course it happens a year or two years after you've been on maternity leave and everyone's forgotten. And I've actually said in an interview, talking about a grant application where people said "Why weren't you involved in this?", and it's like "Well I was at home with twins, I'm sorry, I'm not superhuman, there's only so much I can do". So I just make sure that every application has got my maternity leave included in capital letters, so that I can relate that to the publications, if they're bothered, because I think it's a real issue for the RAE'.

'It was actually the Married Women's Retraining Scheme that brought me back and got me up to scratch for getting through membership, which was just invaluable. I could never had done it without... that was part-time, that was really fantastic'.

'I had a lot of problems coming back to medicine in 2000 because I'd been off with health problems, and because I had already done my specialist training there was just no scheme so I could move from general public health into academic work. I applied for some jobs and the problem was always that I did not have the research experience that I needed in order to do the research. So I think there needs to be a much broader scheme. I'm now applying for the flexible career scheme, but again that's just for clinical, and I think that really needs to be broadened for mainstream academic posts'.

Role models and mentoring

There was overwhelming agreement regarding the importance and value of mentoring and role models for women working in academic medicine. Whilst it was agreed that an effective mentor was valuable for clinical academic women in particular, as they often feel isolated and part of a fragmented group, the gender of the mentor was not an issue, as experiences had shown that both men and women could be effective mentors. There was some debate however, regarding whether mentoring should occur from within the same institution and specialty, from a different institution or a different specialty. Despite this, it was agreed that the key qualities of an effective mentor include being supportive, a sounding board, accessible and inspirational. A need for the mentoring of women in 'focused' and 'assertive' behaviour was identified, so that they are able to compete more effectively with men in an academic environment. It was also suggested that mentoring itself must be valued more within the academic environment, if it is to be effective.

'We've only got one senior academic woman who's a recently-appointed university lecturer, and she's been really brilliant for me, but she's just looked at what I've done and gone "Why did you do that? That did your career no good. Who told you to do that?", and she just went through, bang bang bang. So there's nothing wrong with her focus or her ambition or her career-building whatsoever, and she's empire-building like mad. So she's an exception, but she's actually given me confidence... because she's a woman, if a man had said that I'd have felt really patronised.. Because she is a woman, she's given me a boost to be an awful lot more assertive so far'.

'My mentors were actually sometimes not even in my faculty, they were actually outside my faculty. Now, again, there may be a barrier here between the clinician and the non-clinician, but I found those people really helpful, because they see the bigger picture, they see the much bigger picture'.

'I think at the moment men are in a powerful position in academic medicine and we do need them to actively promote... by not actively promoting they are in essence actively discouraging. We need encouragement, not nothing, not being neutral. Being neutral is as good as discouraging in a way I think'.

'It (the mentor) doesn't have to be a female ...No, it just has to be someone who will be supportive...And give good advice. And dare I say it, I think sometimes men are more supportive than women actually'.

'I think the priority is that they have to be interested in mentoring and they have to be interested in you, and that's actually the fundamental thing and you have to be their priority in terms of helping you'.

Career structure

The need for a more structured career path into academic medicine was identified. It was suggested that flexible career structures, which encourage doctors from a range of backgrounds, not just those from conventional academic backgrounds, into a career in academic medicine should be promoted. Participants suggest that a structured career path needs to be better defined, with both clinical and academic commitments recognised. As part of the academic component, greater recognition needs to be given to teaching. It is recognised that 'academic promotion is biased towards research output rather than teaching'⁴. Many focus group participants were heavily involved in teaching, but felt that they were given little or no credit for this aspect of their work. Although this problem affects both men and women, it is suggested that women are more likely to take on teaching and administration responsibilities.

'We're told explicitly not to teach if we want to get anywhere, because it won't do our CV any good'.

'The reality is that for women there is a stronger possibility that you're going to have a slightly fragmented career path, for whatever reason, which makes you inherently less competitive, and so if you had a fixed contract, based on merit and relevant merit, then you're recognising the potential of people and you're allowing them flexibility to continue with their career path, despite having periods when they're less competitive because they happen to be women'.

'The system of RAE is really against people who teach, and teaching is a crucial matter for all health service... for the community, it's very important, so it's not as valued as research and the pressure on limited time'.

⁴Stewart, P.M. 2002, Academic Medicine: a faltering engine. *BMJ* 324:437-438.

NHS vs. University

It is recognised that increasingly, doctors are 'unwilling to choose a career path which promises little in the way of training structure, job security, flexibility or financial reward and are opting instead for the better security, career and pay offered by purely clinical posts⁵.'

It is widely perceived among participants that a clinical job in the NHS is more secure and less pressurised than an academic job. The prevalence of short-term contracts inherent in academic research particularly, further impacts upon the insecurity of an academic position. Salaries and remuneration associated with academic medicine are also seen to be significantly less than in the NHS.

'I get paid a lot less than people I trained with, I'm on about £15,000 less per annum than somebody I went to medical school with, partly because I don't do on-calls and, if you're talking about retention, that's a big one. I know a lot of my colleagues who've just said "I'm not going into it (academic medicine) for more than six months because I can't afford it because of the big mortgage I have"

'The question of short term contracts and the restrictions that are placed on people in short term contracts for going for major funding is a real barrier to career progress'

'You have a bit of security (in the NHS)... You don't have pressures on you, as long as you stick to your clinical commitments and don't kill anybody'

⁵Goldbeck-Wood, S, 2000, Reviving Academic Medicine in Britain. *BMJ* 320:591-2.

Job expectations

Many participants suggest that current job expectations of a medical academic position are unrealistic and unreasonable. Whilst expectations of an academic research job are high, this is often combined with the pressures of clinical responsibilities. Whilst high job expectations is not a gender-specific issue, expectations of part-time research are particularly high and this has an impact on women, as they are more likely to be in these part-time positions. The importance of reasonable expectations is highlighted, particularly in relation to the RAE, which does little to take into account part-time working.

'I think that's absolutely crucial, because we're coming up to the RAE and everybody's being looked at and saying "Where's your 100%? Here's what you need to be returnable" and I've only done 50% because I'm part-time. It's completely unreasonable'.

'So in a way we are failing before we can start, because if we can't work the 80 hours a week the contract actually does not reflect what's going on. That's the point. There's a big gap, however good the contract is there's a good gap between what it says and what is required to be deliverable'.

'There needs to be part-time expectations...but you are judged on grants and publications, it is not a part-time expectation...I think if your commitment is 60% then your RAE commitment should be 60%, that's two papers a year not three'.

Recommendations

- Awareness of gender issues within the organisational structure needs to be raised in all faculties. A greater commitment is needed towards a long-term view of the situation, with greater emphasis on long-term solutions. Many of the issues raised by women working in a medical academic environment require a gradual shift in culture and perception, not short-term quick fixes.
- A flexible career structure is vital to improving the recruitment and retention of doctors in academic medicine. Central to this is retraining for those who wish to take a career break at some point, particularly women who take time out to have a family. As such the Flexible Careers Scheme should be encouraged and promoted within medical schools. The BMA published a paper on flexible training in 2003⁶; the recommendations from this report should be considered by the university sector and the Modernising Medical Careers academic working party.
- Forms of assessment and accountability, such as the RAE, must be made more flexible in order to take into account part-time and flexible working arrangements and career breaks and measure output in terms of achievement, not hours worked. A RAE target of 60% for part-time academics is suggested as a measure of addressing this issue. The teaching aspect of an academic career must also be taken into account and valued more explicitly.
- Accessibility to appropriate, objective mentors should be available to all medical academics. This mentoring system should be integrated into established structures and given value and credibility. Mentoring schemes such as those set up by the Academy of Medical Sciences for clinician-scientists, should be made available to all medical academics at all levels, from trainee to senior posts. Accessibility is crucial and one suggested method of ensuring this, is to establish a database of appropriate mentors from which medical academics can choose or be allocated a suitable mentor.
- Medical schools and university departments must be made more accountable, particularly in relation to senior appointments. The recruitment process itself needs to be more transparent to avoid the possibility of discrimination of any form.
- A well defined career structure must be established, which includes realistic and appropriate objectives and achievable outcome measures. This career structure must be flexible and progressive. In addition, systems of support should be established and promoted including objective career advice.
- Greater co-ordination between the relevant agencies: the NHS, the Universities and the funding agencies needs to take place if recruitment and retention of medical academics is to be improved.
- Further research is needed if the current recruitment and retention crisis in academic medicine is to be addressed. In particular, the under-representation of women in academic medicine requires further research, specifically in relation to career progression and the recruitment of women to senior positions. Quantitative data disaggregated by gender and age is urgently needed to provide supportive evidence for the key issues identified by qualitative research. Audit and monitoring of gender is required at all levels.

⁶ "Flexible Training – report of the BMA led working party on flexible training", BMA, July 2003.

Appendix

List of institutions of participants

Imperial College, London

Keele University

London School of Hygiene and Tropical Medicine

Institute of Child Health, London

Southampton University

University of Edinburgh Medical School

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