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SEX TYPING OF SPECIALITIES IN MEDICINE

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MASTER OF PHILOSOPHY

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Certificate

This is to certify that the dissertation entitled, "Sex-typing of Specialties in Medicine" submitted by Miss Smita Khanijow in partial fulfilment for the award of the Degree of Master in Philosophy (M. Phil.) of this University is her original work. This dissertation has not been submitted for any other degree of this or any other University.

We recommend this dissertation be placed before the examiners for evaluation.

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Chapter-I

1. Introduction

The present study endeavors to understand how the gender roles acquired during the process of socialization in childhood later on manifest themselves in the adult life. The gender inequalities have led to the division of labour between man and women. The study explores how in the health manpower planning certain characteristics of gendered division are operating. One such area is the choice of specialty among physicians.

The study looks at how the culturally embedded stereotype role of women in society has been a factor in designing the health care labour market and in presenting an option to women physicians to select specialties that have a strong gender bias.

It presents a profile of physicians across six different specialties at King George Medical College, Lucknow looking particularly for their reasons to choose the said specialty and the factors affecting their choice.

An effort has been made to make the necessary conceptual linkages between women's role and her choice of specialty by drawing insights from the primary and secondary research conducted for the study.

1.1 Background

'Gender' refers to socially acquired psychological and cultural characteristic: learned masculinity and femininity. A review of primary and secondary socialization processes brings to light that children learn gender identity through their early social experiences. (Hansen, 1989)

The distinctions made on the basis of gender from stereotyping of girls as 'good and quiet' to boys as 'rough and noisy' feed into and reinforce already existing differences. It is difficult to tease out how far these patterns of social conditioning influence children's behavior in later part of their lives. (Linda, 1984)

These socially constructed sexual asymmetries operate within the large matrix of structural inequalities like class, caste, race and ethnicity which vary within the given time and space.

The gender relations are the key to understand inequalities between men and women— these inequalities are expressed in many ways. One of the more visible and fundamental divisions along lines of gender in adult life is the division of labour.

However the separation between production and reproduction and the hierarchical structuring of enterprises gave rise to segregation and

marginalization of women's work. Therefore leading to female marginalization in the labour market which can be ascertained on the basis of the following four visible dimensions (Scott, 1986)—

- (a) Like exclusion of women from productive employment which can be manifested either in the form of a decline in the overall work participation rates of women or a decline in their share in wages and salaried employment.
- (b) Concentration of all workingwomen in the margins of labour market which is reflected in over crowding of women in the marginal occupations.
- (c) Segregation of women in certain types of jobs which are low in the occupational hierarchy and are low paying and low status, commonly referred to as “feminization or segregation” in employment.
- (d) Wage differentials and casualization of female labor force.

Here it is important to mention the linkage between type of work that defines the class and status of person in the social structure. While issues of work are formed as universal ones, the actual study of work has proceeded along sex-differentiated lines, which have resulted in creation of two sociologies of work.

Thus leading to the construction of separate models for men and women relationship to employment. The dichotomy from which all the male and female differences flowed is a logical outcome of the sexual division of labour as it is evident in the following two models:

- the Job Model for Men
- the Gender Model for Women

These models identify the roles and responsibilities of men and women. The supposition of the Job and Gender Model is that the Men are 'breadwinners and workers' and Women are 'homemakers and wives'. The suppositions of the models are included in the chart below:

Table-1.1: Assumptions of the Job and Gender Model:

Assumptions	Job Model	Gender Model
Basic social relationship is determined by	Work	Family
Family structure is	Male-headed, nuclear	Male-headed
Connection to family is	As economic provider/worker	As wife/mother/home maker
Logical position is determined by	Work	Family
Socio-political behaviour and attitudes determined from	Occupational socialization class/status of occupation, social relations of work	Gender roles, socialization, family roles, attitudes and relationships of household work
Central life interest	Employment and earnings	Family

Source: (Sharma and Singh, 1993)

The Job Model designing is therefore responsible for giving a superior status to men. Meanwhile, the Gender Model explains the variation in the work sphere of men and women.

Health Work offers a rich and complex example of the gender division of labour. In health administration most of the routine non-manual workers are women, whereas, the middle and upper managers are men. This is reflected in the composition of health authorities, hospital trust boards and in the Departments of Health itself (Stacey, 1988). Thus, sex segregation works in two different ways to create a gender division of labour in health sector.

- a) Women and Men in practice are largely restricted to certain types of specialties.
- b) Women are largely confined to lower levels of health occupations, whereas, men climb up the status hierarchy into senior positions. Although certain specialties are more appealing to women than others, given the structure of their experiences, their choices should not be mistaken for expressions of given female nature.

1.2 Focus of the Study

The focus of the study is to examine the unintended consequences of women's occupational strategies, which brings out that the inequalities in the wider society affect the medical division of labour and the health care systems are in turn perpetuating these inequalities. The situation of women health care professionals also indicates that the structural constraints can be discerned in these unintended consequences of actions like choice of specialty.

Despite the sex distribution in today's medical school classes, we have not reached the age of equal representation of the sexes in medicine. Western industrialized countries have seen an increase in the percentage of women enrolling in medical school, and in some countries women entrants outnumber men.

The large proportion of women applying to and being accepted by medical schools provides evidence of equal access. Yet once they are out of medical school, men and women differ in their choices and career paths. As a result, women are still underrepresented in several disciplines such as hospital surgical and medical specialties.

Women are more likely to work in general specialties or primary care and tend to specialize in disciplines that are ranked lower in terms of prestige and earnings.

This breakdown of the sexes by medical specialty is similar to other gender schema. "Since gender schema represent women as more nurturant and expressive and less technically skilful than men, their relative advantage in general practice and relative disadvantage in emergency medicine is not surprising. Women look and act right for general practice, and men look and act right for surgery." (Valian, 1999)

It seems likely that men and women prefer specialties that are congruent with gender schema, they are encouraged to enter such specialties by senior physicians, and they can earn more income in a specialty that is gender congruent. As far as academic careers are concerned, studies have shown a lack of women leaders in academic medicine and women are less likely to have advanced to higher ranks than their male counterparts.

(Schor, 2002)

There is plenty of evidence to suggest that a career in medicine has an impact on the probability that women will marry or have children or both, and women's career choices and advancement seem to be more

influenced by domestic circumstances and family responsibilities than men's. (Fischer, 2001)

Another often cited cause of the under representation of women in leading position in medicine is rigidity in career structures that have arisen favour single men or women with partners providing support at home, enabling them to devote more time to their work. Definitions of success, competence and leadership and the criteria used in selection of new recruits are also based on traits typically attributed to men—for example, toughness and decisiveness. Furthermore, those who make decisions about hiring tend to select candidates who are similar to them. As those in higher ranks of medicine are mostly men, one of the unspoken selection criteria is sex.

1.3 Rationale for the Study

Researchers abroad study the sex - typification of specialties in medical profession. In India, we have some studies to suggest sex typification in various professions. Medical profession, however, has dearth of such studies. Therefore, in order to develop a comprehensive view on the issue, understanding of specialty choices of women physicians appears to be important is in this context that a study was planned among a sample of physicians working at King George Medical College, Lucknow.

The present study endeavours to understand the specialty choice of women physicians and the various factors that have lead to this choice. They are significant in this context as they throw the light upon the sex segregation in medical profession.

1.4 Chapter Scheme:

The study is structured in six chapters beginning with the Chapter-I of introduction where the rationale and the focus of the study is drawn. In Chapter-II the relevant literature on the issue is reviewed which help in conceptualization the research problem and listing the objectives of the study. Based upon the objectives and the hypothesis constructed in Chapter-III the research design and the methodology used are explained. In the Chapters IV and V the findings of the field study are discussed. Finally in the concluding Chapter VI an attempt has been to summarize the main points of the study and highlight the linkages between various factors responsible for the sex typing of specialties in medicine.

The following section reviews the relevant literature on the subject matter.

Chapter-II

2. Review Of Literature

The significance of women's role as a caregiver is recognized and they have not been excluded in careers such as medicine however their position has been limited to lower ranks. The constraints faced by women were largely a result of discriminatory forces. This form of gendered division later on perpetuated while making selection of a specialty choice in medicine. A number of studies have been quoted supporting the above made statements.

The review of literature focuses on the social dimension – the evolution of medical services as well as the understanding of women's professional choice from a social perspective.

The literature survey takes the reader step by step constructing a rationale towards the hypothesis developed and justifying the title of the study. The relevant studies on the subject matter are sub grouped as under:

2.1 Sociological Understanding of Women and Work

In order to develop an understanding of the specialty choice of women physicians firstly it is important to consider some of the approaches at the start itself:

The inadequacy of gender analysis within classical sociology has given way to various approaches analyzing women their work and their status. (Cook and Fonow, 1986).

Women's wage labour under capitalism has been developed systematically in sociology. According to Grint (1991), there are various theoretical approaches in analyzing women and work such as:

- a) Classical perspectives of women and work— where Weber is considering the patriarchal domination as normal in the view of male physical and intellectual superiority.
- b) Gender as 'irrelevant'— in which family is the unit of analysis which provides a theoretical justification for exclusion of gender;
- c) Gender as secondary or derived from class subordination
- d) Patriarchally derived subordination—where gender inequality is derived from capitalist patriarchy
- e) Dualist subordination where gender inequality is related with interaction of autonomous spheres of capitalism and patriarchy and
- f) Contingent subordination—in which gender inequality is derived from heterogeneous factors like gender, ethnicity and class but connections and influences are contingently interpreted and tension ridden.

Under capitalist production and social relations, the division of labour at home is closely linked with the division of labour at workplace and the conditions under which women enter the labour market (Moore, 1988).

Marxist analysis of women workers as the “reserve army” under capitalism is closely linked with the lower payment of women in the job market due to the capitalist assumption that women are primarily economically dependent on men and therefore women can be paid less.

The gender ideologies implicit in household organization and labour market segmentation play a crucial role in women’s domestic labour and her access to the labour market (Walby, 1994). The category of women’s domestic, as well as reproductive work and subsistence production is largely ignored (Thompson, 1988)

2.2 Women as Unpaid Health Care Worker

The labour market enlists women as the health care workers at two levels in the society. One at the household level and other is through participation in the organized health service system.

Women play a very important role in treating and caring for the sick in the family-this stems from their reproductive and nurturing roles. This involves varied functions ranging from providing food, nurturing the

children, nursing the sick, caring for the convalescing and disabled members in the family. However the women's role as health care provider for the sick and elderly in the family is invisible and unaccounted for as productive economic work. It remains unpaid. (Linda, 1984)

2.3 Women in Medicine

Just as philosophers and social scientists constructed images of women within the constraints of the socio-political environment of that time, so did science and medicine.

Despite of all their claims of objectivity both science and medicine are based on assumption, which taint the image of their subjects that they create. These assumptions reflect the biases that prevail within the social environment of scientists and medical professionals (Lewing, 1985).

It becomes necessary to look at socio political and economic system that gain much in power, privileges and profits for itself and for individual men from the sub-ordinate position of women.

Medicine has played and continues to play a powerful role as a reinforcer and perpetuator of sexist ideology as brought through the following examples: (Olessen, 1985)

- Women were not excluded from medical education and practise in the 13th and 14th century. In medieval period witch-hunt was at its perk and many of these were women healers. Though witch-hunt was a part of larger soico-political changes but its impact on women healers was significant.
- Secondly, professionalisation in medical field began in late 15th century onwards. It started with changes in economic and political filed. From 17th century onwards advancements in scientific filed had much to contribute in professionalisation. With this though women continued to be in the medical field, they were confined to much lower ranks.
- With advancements in medical and scientific field, normal body functions were medicalised. It provided medical view of pregnancy and women's disease so as to fit in the prescribed social roles.
- And finally state's interest in material and child health after World War I was not only motivated by the welfare orientation but again was a part of much larger socio-economic and political interest.

2.4 Indian Women's Entry into Medical Education

The entry of women into medical education in the late 19th century was necessitated by the strict *purdah* system practiced not only by Muslims but also by Hindus. The *purdah* system prevented women from being

attended by male doctors a circumstance that led to a high rate of maternal and child mortality (Lebra, 1984).

In addition, the low social status accorded to women in India resulted in the neglect of their health (Mehta, 1982). Girls were looked upon as a burden, and their health was generally not attended to except at times of sickness and childbirth. Moreover the custom of feeding all the men folks and children of the house first, women eating last, often left women with little nutritious food. Frequently, malnutrition and anemia were the most common causes of high maternal and child mortality. Furthermore, the custom of child marriage often resulted in health problems among young mothers (Mamoria, 1981).

Illiterate and untrained nurses who had learnt midwifery by experience and from their female elders usually attended births. All these conditions created a need for qualified women doctors to provide health care to Indian women.

The first organized attempt to teach medicine to women was made in the late 19th century by one Mrs. Scarlieb in Madras Presidency, an English woman who accompanied her barrister husband to India. Moved by the plight of Indian women who died during delivery, she underwent a one-year course in midwifery but found her training inadequate. The

initiative of Mrs. Scarlieb led in 1875 to her admittance and four other women to the three-year certificate course at Madras Medical College. While the Universities and medical associations in Great Britain were debating whether women should be permitted to study medicine, this progressive step was taken in India (Jaggi, 1979).

In short, the entry of women into medical education was motivated by the need for women doctors to serve Indian women. Conscious efforts were made by the British government, Western missionaries and social reformers in the midst of a social milieu that did not favour even basic education for women. The women and their families, who broke with tradition by entering into the profession, had to fight the social opposition of the day. But the status of women doctors gradually rose and is today well established (Abidi, 1980).

Medicine and teaching were the first professions where women were accepted in. The ideal of service, the "ideal of healing", the high social status and the monetary gains continue to attract women from high caste and class into the profession. As the history of medical education in India shows, women were admitted to medical schools before an all male tradition had been established (Lebra, 1984).

2.5 Women's Choices and Structural Constraints

Institutional explanations of the sex segregation of occupations have questioned the assumption that women are concentrated in certain occupations only because these occupations are compatible with women's domestic roles or because they reflect preferences formed during gender socialization (Sanderson, 1990). The tendency for women to cluster, however in medical specialties lacking the characteristics generally attributed to professional work cannot be attributed solely to overt or covert discrimination.

In fact, the choice of specialty is often the outcome of a skillful balancing of professional and family demands and by informed evaluations of obstacles and opportunities in the profession (Riska and Wegar 1988).

This notion of women's occupational choices as strategies based on knowledgeable assessments of the opportunity structure fits the human capital theory of career paths selected by gender (Crompton, 1990).

The gender-based division of labour in medicine is characterized by different claims of managing medical uncertainty. While the male dominated areas of medicine are characterized by efforts to expand the scientific and technical mastery of the body, the female-dominated areas are characterized by the mastery of patient's emotions.

Today, women physicians in primary care can appeal to a management and mastery not only of patients' feelings but also to the whole array of uncertainty related to what Armstrong (1983) has called the illness related to social spaces.

This area of medicine approaches illness from the viewpoint of social relations and the social and cultural factors embedded in these relations. The effort to matter these factors has led to the establishment of a variety of specialty field in primary care. By claiming the rôle of interaction or communication experts, women have been able to enter these new niches in medicine.

Ultimately, however such stereotyping of expertise might restrict women's occupational choice, and also intensify the occupational hierarchy in health-care organizations. The clustering of women in positions as lower paid communication technicians is a common phenomenon not only in the health care filed, but also in many other occupations (Reskin and Ross, 1990).

The gendered division of labour in health care has also been attributed to more subtle processes of socialization that shape women's preferences. Much research on gender specific traits and preferences among medical

students and physicians has explicitly or implicitly relied upon the individualistic framework of sex role theory (Riska and Wegar, 1979).

This approach explains gender differences in attitudes by the different role expectations that women and men face during periods of socialization. However as critics have pointed out socialization and role theory is basically voluntaristic and excludes issues of power and social interests. Hence such interpretations fail to take into account the social character of motives (Connell, 1987).

To regard motives as socially constituted means that the motivational processes are internalization of existing social roles and power relations and that people's motivations are mediated by the socially constructed vocabularies of motive they employ (Mills, 1940).

While the view that motives are internal of social relations stems from the classical median tradition of social psychology, the idea that motives cannot be grasped except through an understanding of socially constructed vocabularies of motive has only recently been rediscovered by "poststructuralist" researchers (Silverman, 1989).

The poststructuralist approach to the analysis of gender-specific preferences of occupation questions the view that women's choices are

direct manifestations of their inner nature as well as the assumptions that can be grasped in its pure form. The different theoretical perspectives largely guide the extent to which women's occupational choices are seen circumscribed by structure of domination.

While structural explanations focus on institutional barriers to advancement, interactionist studies of the micro-politics of power are more likely to recognize women's emancipatory strategies (Carpenter, 1998).

The debate between proponents of the structural approach and theorists who emphasize women's interests and occupational choices effects a fundamental disagreement over the relative importance of agency and structure in explaining human behaviour.

2.6 Specialty Choices of Women

The vertical and horizontal divisions, which constitute occupational segregation, were also found in health services on both sides of the Atlantic. The health-care division of labour is dominated by the medical profession, itself predominantly male. Doyal (1978) stated nearly 55% of all doctors on the British Medical Association (U.K) register were women.

In the US however reports show that 30% of medical students are women. In both countries, medical school staffs as all elite medical groups, remain predominantly male, particularly in the higher status grades.

In both the countries women are disproportionately represented in other. Doyal (1978) lists child and adolescent psychiatry, mental handicap, anaesthetics, radio-therapy and medical microbiology as the top "feminine" specialties in the UK, while for US Marskind (1980) shows that pediatrics is the most popular choice for women physicians followed by psychiatry, anesthesiology, radiology and obstetrics and gynecology.

Indeed, in the UK as in the US, men dominate most forms of surgery. Allowing the differences in the organization of specialties it does seem that there are considerable similarities between the two countries.

First, women are found disproportionately in the available specialties i.e. the less popular fields where they find it easier to get appointments and promotion. Secondly, women encouraged by their male partners feel that women can combine harmoniously her occupational demands with her domestic duties, including child bearing.

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A widely accepted explanation of the concentration of women in certain fields is that of reduction of role conflict by women. "Women doctors tend manage their professional career by selecting for work those fields of medicine and that type of practice which are least likely to offer work duties incompatible with the family task" (Kosa and Kiker, 1965).

This approach suggests that women experiences will make them choose specialties:

- a) in which they have special expertise or experiences because of their primary roles as women, wives or mothers or
- b) which have suitable working arrangements to fit those primary roles.

There are number of studies which support the above made generalization. Some of these studies are reviewed as under:

In a study conducted by Haraway (2000) at Massachusetts General Hospital and Boston University School of Medicine found that many women physicians teaching at medical schools perceive that they are discriminated against and sexually harassed. The study found female faculties were more than 2.5 times likely to perceive gender discrimination in their work environment. (77% women vs. 30% men). And more than half of the women reported that gender bias had hindered their professional advancement, compared with 9% of men. More than

half of responding female faculty reported being sexually harassed by a superior or colleague, compared to 5% of men.

It was also found that sexual harassment was twice as likely to be reported from certain fields, for instance, female surgeons and other physicians in male dominated specialties than from women in primary care. The study addresses the disparity as the saddest thing and nothing but “gender disconnect”. The vast majority of women medical faculty at all stages in their career suspect that gender bias is both a personal and systematic problem in medical academia”, (Ash, 2000).

Another intervention study by Halpren (1996) conducted at Department of Medicine, John Hopkins University School has tried to determine the gender based career obstacles for women in an academic department. The study found two-third of the women faculty reporting timeliness of promotions, manifestations of gender bias, isolation, salary inequity. Men also confirmed the observations made.

In Britain the position of women doctors has changed overtime. In 1990, 15% of all NHS consultants in England and Wales were women. In 1977, they were 10% (DH National Medical Staff tables 1978, 1991). So there has clearly been an increase over the decade as the numbers of qualified women on the training ladder have increased. But given that women

have been 20% of qualifiers for 40 years, they are still considerably below the proportion one would expect from an even distribution across the main sectors of medicine.

Allen (1988) found that women were more likely than men to perceive sponsorship as more easily obtained by men and as more fateful in the highly competitive high-status specialties such as medicine and surgery.

Even if ill founded, belief in differential sponsorship may condition women's aspirations and specialty choice. This may be one factor in the longstanding differences in the presence of women in different specialties.

In general, at registrar level and above, there are a higher proportion of women in shortage specialties compared to competitive ones, in the service specialties compared to direct patient care ones, in medical specialties compared to surgical ones and in child medicine compared to adult medicine.

This overall above stated pattern has changed little over the past decade. There is no reason to think any one factor can explain the whole of this pattern. Rather it is the outcome of a constellation of factors relating to

different specialties and of factors relating to individual doctors who might work in them, the two sets often becoming conflated in practice.

Thus women's specialty preferences on qualifying and subsequently do tend to show some differences from men's but these preferences may be partly conditioned by knowledge of the obstacles and opportunities.

Some field may be particularly attractive to women because of the nature of the work. But, in the context of state policy for expansion of some fields faster than normal recruitment would have permitted, there has been incentive to encourage women's access to these fields, perhaps reducing the pressure on others to change (Stacy, 1987).

Two areas where women are poorly represented warrant particular comments: surgery and Obstetrics and Gynecology. As in many Western countries, women in Britain have long been poorly represented in surgery. In 1990, women were only 3% of all consultants in surgical specialties, the 11 new appointments in the previous year representing 10% of the total in past. Furthermore, half of the women surgeons were specialists in pediatric surgery, with only 12 women as general surgeons and 4 women cardio-thoracic surgeons in the whole of England and Wales. (Lober, 1984)

Surveys such as Allen's (1988) have shown that many factors which combine to make surgery appear "a white male preserve"; these include strong competition, long demanding training with very limited part-time provision a "macho" image of consultant type. Surgery has been very resistant to the routinization of its training requirements, in that great emphasis is placed on "total immersion" of the neophyte in the work.

But there is a small sign of change. In 1991, concern about the low level of female appointments in surgery has led to the establishment of a government funded scheme for those few intrepid women considering a surgical career a low key approach to overcoming some of the hurdles individual women face.

In Britain, unlike in many other Western countries, Obstetrics and Gynecology has not recently been a "women's field". In 1988, women were 12% of consultants in the field, a proportion that has risen slightly over the last decade. Many of the some obstacles that women face in surgery apply here, not least because obstetrics and Gynecology training has ebon regarded as primarily surgical training for much of the last 50 years.

It too has resisted routinization of training although more opportunities for part-time training have been created very recently. The experience

thus shows that it is a grueling struggle for a woman to pursue a specialist career in Britain today. (Allen, 1988, Survey 1989)

To sum up one can say that the macro structural perspectives allowing a thorough examination of the external environment of the health care delivery system demonstrates that gender inequalities are not simply “internal” to this sector but form a part of and are affected by the micro socio-political inequality of men and women in the society.

2.7 Conceptualization of the Research Problem

The inter linkages in the factors operating while making a specialty choice and their implications need to be further explored. The choice of specialty depends upon many factors. The flowchart in Figure 2.7a explains how the interaction and interdependence of various factors influences the choice of specialty choice of a women physician..

Based upon the basic understanding of the factors depicted in the flowchart and their operation the present reading is supported by an exploratory study of the socio-economic and career profile of the medical professionals in selected departments at King George Medical College, Lucknow.

Conceptualization of interaction between the factors shaping the specialty choice

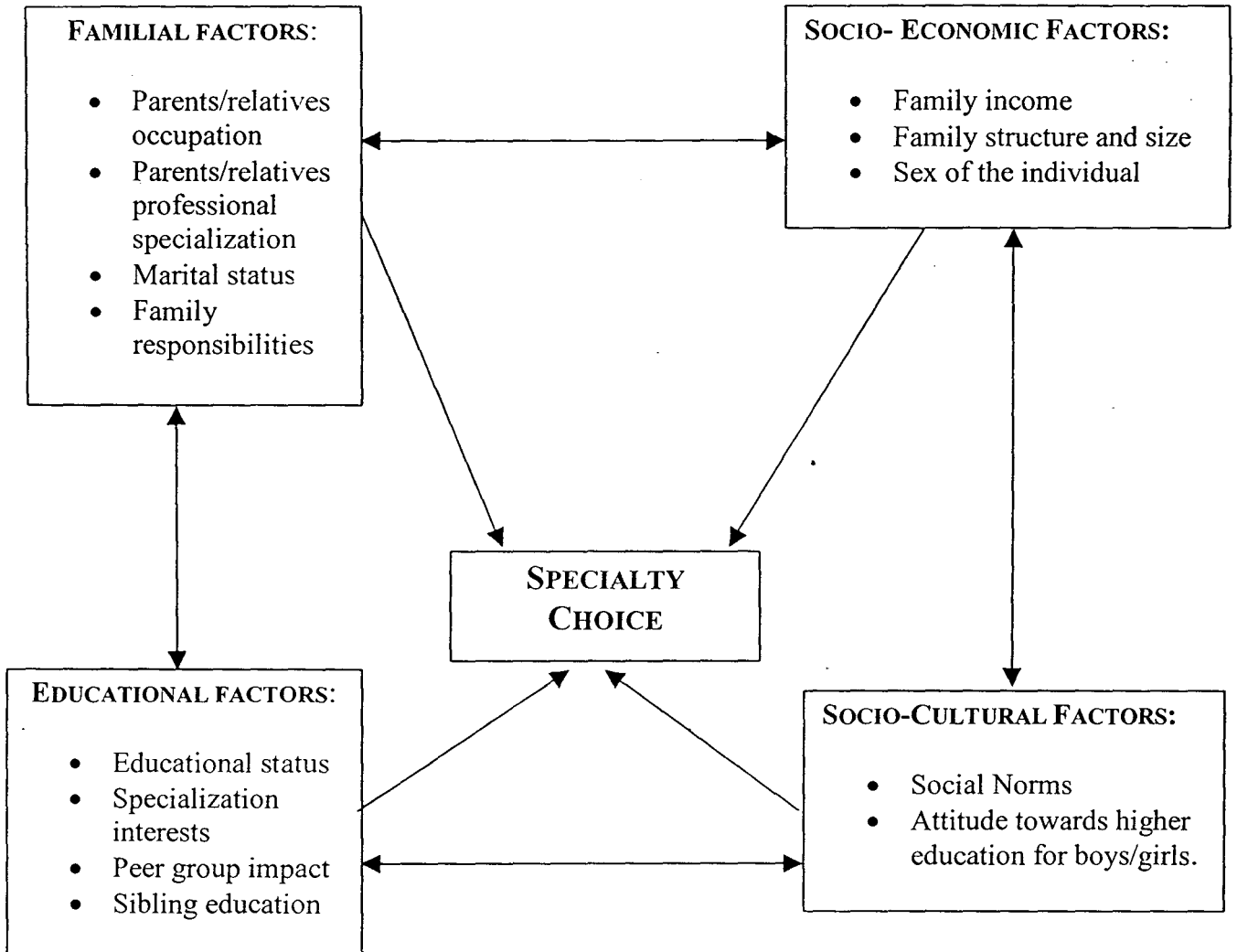


Figure-2.1

2.8 Research Objectives

The aim of study is to examine the distribution of specialty choices in medicine among women doctors. The specific objectives of the study are as under:

- To understand the sex-typing of specialties among women physicians in King George Medical College, Lucknow.
- To examine the factors responsible for sex-typing in medical practice.
- To study the attitude of men colleagues/family members towards women as professionals.
- To explore the factors, which are responsible for making physicians, depart from practicing traditional specialties and the related constraints in doing so.

2.9 Hypothesis

The positional inequality applicable to women in health occupations suggests—

- There is sex-typing of specialties in medicine.
- There is limited possibility for women doctors to practice non-traditional specialties.

In lieu to achieve the objectives listed, in the next section an attempt has been made to explain the research design and the methodology used to do an exploratory study of medical professionals at King George Medical Collge, Lucknow.

Chapter-III

3. Research Design

The present study is primarily exploratory in nature and the research design used and developed included secondary and primary data collection. In order to develop a comprehensive view on sex typing of specialties in medicine an understanding of specialty choice of women physicians is important. Hence the primary data was obtained through a sample study of physicians at King George Medical College Lucknow.

3.1 Area of Study

King George Medical College, Lucknow, U.P. was selected for the study. Lucknow is the State capital of Uttar Pradesh. The district has five main government hospitals and an array of private clinics. The KGMC, is one of the oldest and reputed medical college in the country. It is situated in the old City on bank of River Gomti and boasts of beautiful British architecture.

The college aims to integrate modern medicine into the resource deficient environment of our developing country. The KGMC, is a constituent college of University of Lucknow and is committed to the three basic objectives:

The College aims to:

- Providing quality medical education
- Health care services and
- Research

The hospital attached to the KGMC is called the Gandhi Memorial and Associated Hospitals. This is a hospital complex spread over a large area with a conglomeration of buildings housing various departments and their respective wards.

The main hospital building houses the Radio-diagnosis, Radiotherapy, Orthopedics Surgery and ENT departments. It also has the offices and surgical wards there are separate buildings for the Tuberculosis and Chest diseases, Medicine, Pediatrics, Ophthalmic, Obstetrics and Gynecology, Surgery, Psychiatry, Cardiology, Neurology and Pathology departments.

There are also separate out patient departments such as Accident and Emergency department and Department (Casualty) buildings. The total number of beds is 2200 with a bed occupancy rate of 90-100%. The annual outpatient attendance is about 500,000 and the indoor admissions number about 40,000/year*. The hospital provides specialty

services in all branches of medicine. Patients are attended to and admissions are made round the clock. (*Source: KGMC official records)

This is a University run hospital where all medical, surgical and nursing care was provided free of cost. However, charges were introduced in August 2000. Patients now have to pay a nominal charge for admission to hospital and for investigations done here. In addition, patients may have to buy drugs and disposables, as the hospital does not supply free medicines to the patients.

All the faculty members of clinical departments of KGMC are attached to the hospital as visiting consultants. Besides, the hospital has its own full time staff both administrative and technical.

The hospital is managed by 200 consultants, 500 resident doctors, 400 nurses, 60 Pharmacists, 100 technical and paramedical, 50 clerical and 1000 ancillary staff*. (*Source: KGMC official records)

The King George's Medical College provides educational opportunities in biomedical sciences as it is actively involved in various kinds of research projects. Currently 1250 undergraduate students and 450 post-graduate students are enrolled. It has 28 departments— including 8 super specialty departments and about 200 faculty members.

Table-3.1 List of Departments at KGMC, Lucknow

CLINICAL DEPARTMENTS	
Medicine	Orthopedics
Gynecology and Obstetrics	Forensic
Ophthalmology	Radio diagnosis
Pediatrics	Radiotherapy
Psychiatry	Pathology
Surgery (General)	TB and Chest
Plastic Surgery	Urology
Neuro surgery	ENT
Pediatric surgery	Anesthesiology
Surgical oncology	Cardiology
Thoracic cardiovascular surgery	Neurology
NON-CLINICAL DEPARTMENTS	
Anatomy	Physiology
Biochemistry	Social and Preventive medicine
Microbiology	Pharmacology

Table-3.2 -List of Departments and Description of Faculty

CLINICAL DEPT.	MALE PHYSICIANS	FEMALE PHYSICIANS
Anesthesiology	6	10
Cardiology	5	0
ENT	3	0
Medicine	15	0
Neurology	3	0
Gynecology and Obstetrics	0	12
Ophthalmology	5	3
Pediatrics	3	5
Psychiatry	10	0
Surgery (General)	11	0
Plastic Surgery	4	1
Neuro Surgery	2	0
Pediatric Surgery	3	0
Surgical oncology	3	0
TC.V Surgery	2	0
Orthopedics	7	0
Forensic	2	0
Radio diagnosis	3	3
Radiotherapy	5	2
Pathology	11	3
TB and Chest	3	0
Urology	2	0
NON-CLINICAL DEPT.	MALE PHYSICIANS	FEMALE PHYSICIANS
Anatomy	5	0
Biochemistry	4	2
Microbiology	5	3
Pharmacology	5	2
Physiology	2	3
SPM	11	3

It is evident from the above table that there are certain departments in which there are no male physicians example- Gynecology and Obstetrics. And other departments for example Surgery in which there are no female physicians. Meanwhile, there are departments, which are either male dominated or female dominated. For example Pediatric, Anesthesiology number of female to male physicians is more as compared to TB and Chest, Neurology where there are no female physicians.

3.2 Selection of Respondents

The selection of respondents for the field study included male and female physicians across six different specialties at KGMC, Lucknow namely- Anesthesiology, Pediatrics, TB and Chest, Surgery, Neurology, Gynecology and Obstetrics. The respondents were selected from these departments, as the segregation by gender was most visible in these departments.

Table-3.2 List of Departments chosen for study and the description of faculty

Specialties	No. of Male	No. of Female	Junior Residents
Anesthesiology	6	10	2
Pediatrics	3	5	2
TB and Chest	3	0	2
Surgery	11	0	2
Neurology	3	0	2
Gynae & Obst.	0	12	2

However practically it proved to be difficult to get access to all respondents in each department during the working hours.

Thus finally, a sample of 35 respondents was selected from the six departments at KGMC—Anesthesiology (2male; 5 female; 2 Junior Residents), Gynecology and Obstetrics (0 male; 6female and 2 Junior Residents), Pediatrics (1male; 2 female; 2 Junior Residents), TB and Chest (1male; 0 female; 2 Junior Residents, Neurology (1male; 0 female; 2 Junior Residents), Surgery (5male; 0 female; 2 Junior Residents).

Table-3.2 Number of Respondents and their respective departments

Specialties	No. of Male	No. of Female	Junior Residents
Anesthesiology	2	5	2
Pediatrics	1	2	2
TB and Chest	1	0	2
Surgery	5	0	2
Neurology	1	0	2
Gynae & Obst.	0	6	2

In total 13 females; 10 male and 12 Junior Residents were selected as respondents.

3.3 Methodology

3.31 Secondary Data Collection

As part of preliminary data collection a parallel process of secondary data began alongside the field study. The secondary data was aimed at examining the administrative documents and reports from KGMC, Lucknow. Efforts were also made to collect material from various journals like Annals of Internal medicine, JAMA, EPW and from documentation of similar studies done by other organisations and newspaper clippings.

3.32 Primary Data Collection

Preparatory work:

The primary field study was conducted from 22nd September 2001 to 31st December 31st 2002. First for the purpose of study the investigator had to seek permission from the K.G.M.C. Principal, Mr. KM Singh to meet the physicians during working hours of College. A letter from Center of Social Medicine and Community Health of Jawahar Lal Nehru University, New Delhi requesting for allowing the researcher for the rationale helped in obtaining the required permit.

The importance of study to be done and how it could help in manpower planning at the hospital in future was explained to the Principal of

KGMC. On being convinced that the study to be conducted will not bring any harm to the hospital, all help was extended by the KGMC Principal.

A formative research was carried out in the beginning of the study. Formative study included the visit of King George Medical College, Lucknow (KGMC) and general discussion around the subject with physicians in different departments.

Based on discussions with physicians on the subject a close-ended questionnaire was developed and tested at the same research site. Incorporating the feedbacks from the testing, the final questionnaire was developed. The final questionnaire included questions on basic demographic, socio and economic characteristics and issues related to gender and sex typification in medicine. (***Appendices 1***).

The Field Study:

Prior to meeting the respondents an appointment was taken with the physicians over telephone. During the telephonic conversation purpose of the study and its rationale was explained to the respondents. This helped in two ways- the respondent became clear of the objective behind the study and also, the concerned physician allocated a particular work hour in which she/he could devote full concentration to the investigator's queries.

Most respondents appreciated the researcher's concern and were keen to know about the nature of study and how it could be beneficial to them. Regular visit to the hospital and use of skills to gain confidence finally helped in collecting data on sensitive issues such as reaction of male/female colleagues, wife/husband to professional work, all of which was necessary for strengthening the findings of the study.

3.33 Tools and Techniques of Data Collection

A variety of tools were used for collecting data from different sources to get a comprehensive understanding of specialty choice of physicians.

Quantitative Tools

For the primary research, a **questionnaire** was piloted among the physicians selected as respondents from the departments under study. With the help of questionnaire information that was sought can be divided under the following heads:

Identifying information- It included questions on demography, socio economic and gender profile of the selected respondents.

Empirical information- This included the number of male and female physicians in a particular specialty department under study and number of selected respondents.

Subject matter of the study-The questionnaire administered included questions on issues of career choice, specialty choice, the reasons for same and on sex typing of specialties in medicine.

While the questionnaire was used as a tool to gather information, the main technique used for fielding questionnaire was that of **interviews**.

During an interview, the researcher sought opinion of the respondents face to face on queries pertinent to the research study. A process of rapport building was initiated at the start of each interview. All the interviews took place at the respective departments of medicine.

Qualitative Tools

Observation was one of the key tools in getting qualitative data in research on the subject. During the course of research study the investigator in a non-participant manner observed the respondents and their responses while administering the questionnaire and conducting the group discussions. The essential points were noted by the investigator in her field diary. This helped in exploring the possibilities of data collection focusing on many aspects of gender issues, which otherwise we may not have noticed.

Small group and informal discussions were also applied during the research process. These were rich sources of collecting insights into the perceptions regarding key issues of women physicians in general. The

informal interviews were focused on the specific issue of sex typing of specialties in medicine. The respondents were free to share their own experiences in their own words, unfettered by pre-established categories in the questionnaire. These discussions permitted interviewer some flexibility in the choice of questions; as the responses were open ended therefore information provided the respondent's viewpoint. The discussions brought out their awareness and notions regarding professional work, their role in families, their interaction with the colleagues and perception about gender relations in health care organization they are serving.

3.4 Field Notes

While collecting the data investigator maintained two types of records: Field notes and Daily diaries. During the fieldwork all discussions with the respondents and perceptions of specific interviews were noted in fieldwork records. Later on the basis of which consolidated report was written in daily diaries. This information was useful in verifying the information entered in questionnaire and clearing doubts that arose in the course of data entry.

The respondents were asked to fill a structured questionnaire that contained questions pertaining to reasons and factors affecting their

choice of specialty. The data collected thus was coded and processed appropriately. This helped in analysis of findings, which was then dealt under the following sub headings:

- Socio-economic and demographic profile of medical professionals
- Career profile of the medical professionals
 - Medicine as a career
 - Choice of specialty
 - Reasons for selecting the said specialty
 - Factors affecting selection of specialty
 - Norms restricting choice of specialty
 - Perceptions of respondents

3.5 Limitations

The results of the study should be interpreted in light of the following considerations:

3.51 Primary Research

While the sample size was small, compilation of the primary research had to be extended beyond the scheduled time frame due to delays in the completion of questionnaires by the different respondents, especially the physicians at Surgery and Neurology Departments.

In the case of Pediatric, Obstetrics and Gynecology Department also, it was not always possible to get respondents to a setting at a definite time. This was because the questionnaire was administered during working hours and often due to emergencies in specialty departments demanding immediate attention of physicians.

Questions on intimate matters such as opinion of family on professional choice, family responsibilities were also difficult to tackle initially. This hesitation was visible, as respondents seemed to feel uncomfortable discussing openly questions related to family and professional relationships. Therefore during the process of rapport building a lot of time had to be spent with the respondents to gain their trust and make them comfortable in discussing these issues. With time and patience, these barriers were broken to allow for open sharing.

The data is based in self-reports, which relies in perceptions and is vulnerable to criticisms of validity.

3.52 Secondary Research

The collection of statistical data proved to be a difficult as though the number of men and women physicians employed by the organization was available but their distribution across the specialties was not tabulated. Therefore the tabulation proved to be a time-consuming exercise.

Chapter-IV

4. Socio-Economic and Demographic profile

Within the purview of this study, a questionnaire was used to document sex wise preference for specialties among women physicians across six different branches in medicine. The data was collected to develop an understanding of the factors affecting the choice of specialties of women physicians. This section presents findings of the primary research in the field.

King George Medical College, Lucknow, U.P. was selected for the study. Lucknow is the State capital of Uttar Pradesh. The district has five main government hospitals and an array of approximately 300 private clinics.

The sample for the field study included men and women physicians across six different specialties in KGMC i.e. Anesthesiology, Pediatrics, TB and Chest, Surgery, Neurology, Gynecology and Obstetrics. The respondents were selected from these departments, as the segregation by sex was most visible in them.

Table: 4 Distribution men and women respondents across six specialties

Specialties	No. Of Male	No. Of Female	Jr. Residents
Anesthesiology	2	5	2
Pediatrics	1	2	2
TB and Chest	1	0	2
Surgery	5	0	2
Neurology	1	0	2
Gynae & Obst.	0	6	2

A sample of 35 respondents was selected from the six departments at KGMC. In total 13 females; 10 male and 12 Junior Residents were selected as respondents.

The socio-economic and demographic profile of 35 physicians selected as respondents across the six different specialties at KGMC, Lucknow, is as follows:

4.1 Age structure and Sex composition of respondents:

The data obtained for age was arranged in two series with age range of above 40 years and below 40 years. The results show that out of the 35 respondents, 13 were above 40 years of age and 22 were below 40 years of age. Out of those above 40 years in age 5 were males and 8 females. And out of those below 40 years in age 11 were males and 11 females.

Age Structure of respondents

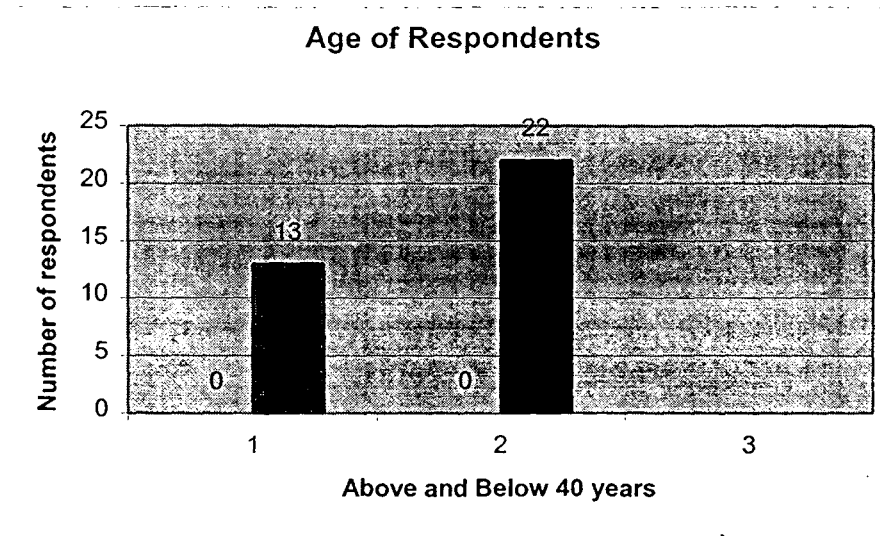


Figure- 4.1

As seen in the Figure 4.1 the number of men and women respondents in the age range below 40 years is equal. However for the category above 40 years of age the number of women respondents is more. Hence the opinion of the men and women respondents in the latter category may vary due to age difference and therefore different set of experiences over time.

As seen in Figure 4.2 out of the selected set of 35 respondents, 16 are males and 19 are females. The number of female respondents is more than male respondents therefore the findings might have an interpretation from a female perspective.

Sex of respondents

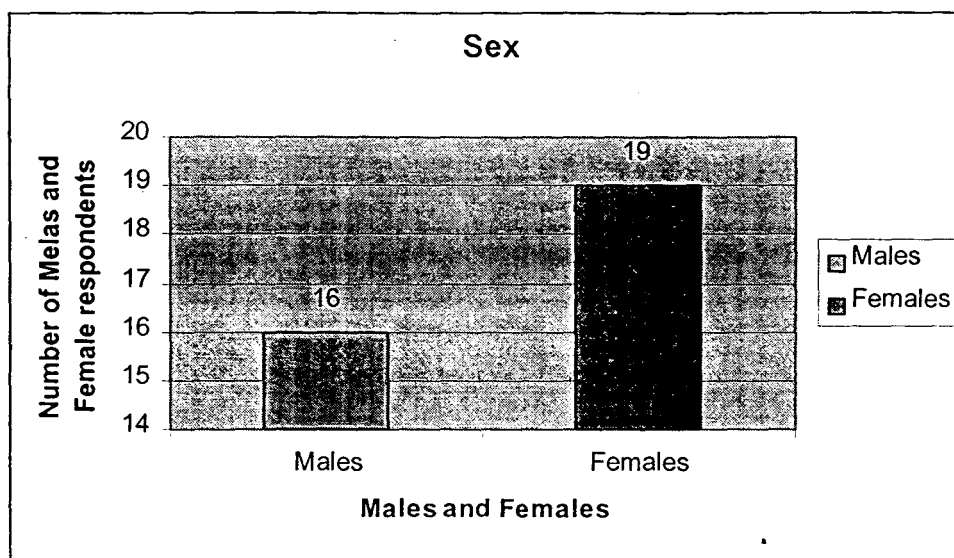


Figure 4.2

4.2 Marital Status:

Marriageable age of men and women vary in Indian setting. Generally, it seen that women get married at a younger age compared to men. Figure-4.3 shows that in this study out of 35 respondents, 29 are married and 6 respondents are single.

Marital Status of Respondents

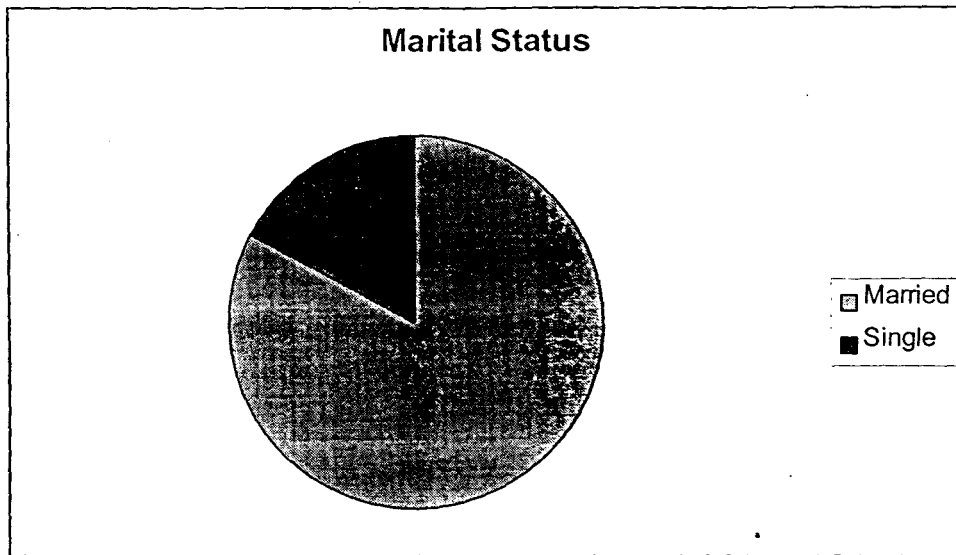


Figure-4.3

Out of 6 unmarried respondents 4 are females and 2 are males. Out of 29 married respondents 14 are males and 15 are females. The data showed that both men and women respondents who are single in status are below 40 years in age, thus as these respondents are still in the reproductive age group therefore there are chances of them getting married in near future. Hence the interpretation that due to demands of given career or choice of the said specialty they could not get married is not valid here.

4.3 Migrant Status of the respondents:

The data obtained was categorized in two sets of respondents one those whose native place is State of Uttar Pradesh and the second of those who are from outside Uttar Pradesh. This was done to ascertain the migrant status of respondents. The figure 4.d brings out that the most out of 35 respondents are from the State of Uttar Pradesh. And only 6 respondents are reported to be from outside the State. Out of 6 respondents who are from outside UP, 2 are males and 4 are females.

Migrant Status of respondents

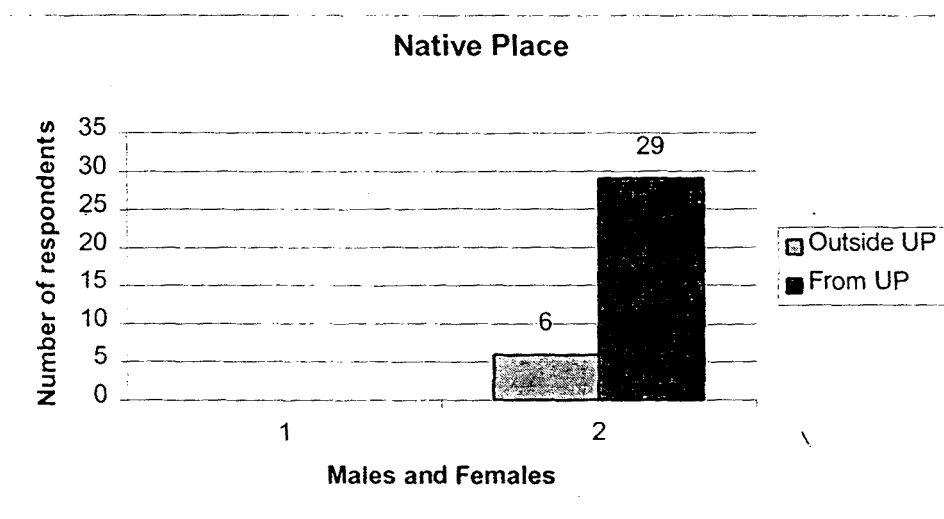


Figure 4.4

Thus the findings are more applicable to the settings found in State of Uttar Pradesh.

4.4 Family size and Structure:

As seen in the Figure-4.5 the data for the family size and structure of the respondents can be classified in three series. The findings of the study brings out that the family structure of 35 respondents is consists of 19 respondents having a family size of 3-4 members. 14 respondents having 5-6 members in their family and 2 respondents have family of 7 and more members.

Family size and Structure

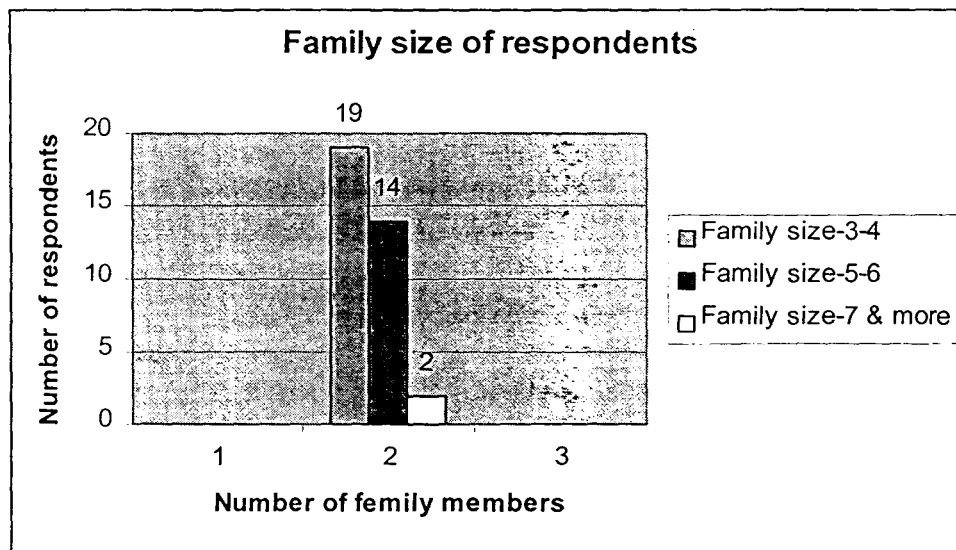


Figure-4.5

Thus most of the respondents are married having nuclear family set up to support.

4.5 Worker and Non-worker profile:

The Figure-4.6 shows the number of respondents and the number of earning hands in their families. The results show that the majority of 35 respondents have two or more earning members in the family. Among them 20 respondents have 2 earning members in the family; 8 respondents have 3; 4 respondents are dependent only on 1 earning member i.e. the respondent and 3 respondents have 4 and more earning members in the family.

Worker and Non-worker profile

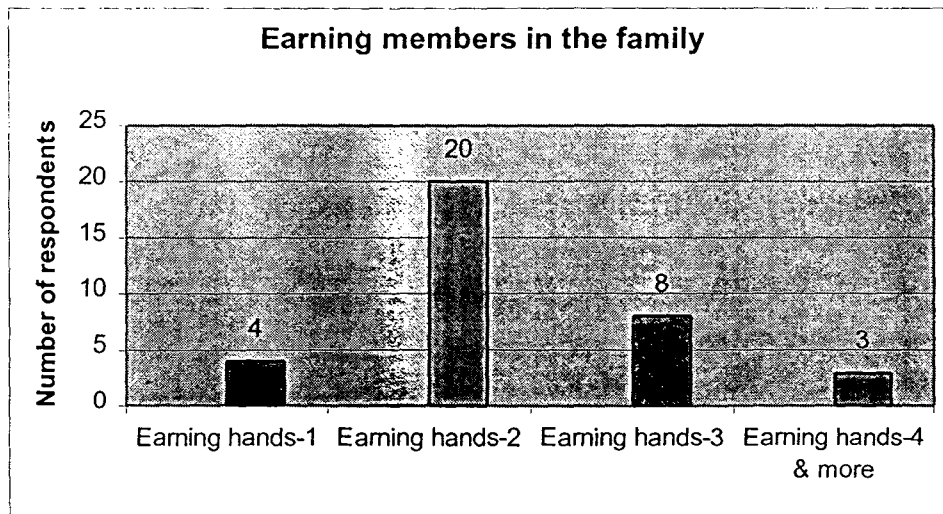


Figure-4.6

The respondents with 4 and more earning members in family have a family size of 7& more members. The analysis reveals that the

respondents are not dependent on any other member or person outside their family set up for income to support the household.

4.6 Educational Qualifications:

The 35 respondents included those who are doing M.D, called the Junior Residents and those have completed M.B.B.S. and M.D. The Figure-4.7 shows that among the respondents 23 are M.B.B.S. and M.D. And 12 have completed MBBS and are doing M.D. Thus the majority of the respondents had completed M.B.B.S. and M.D.

Educational qualifications of respondents

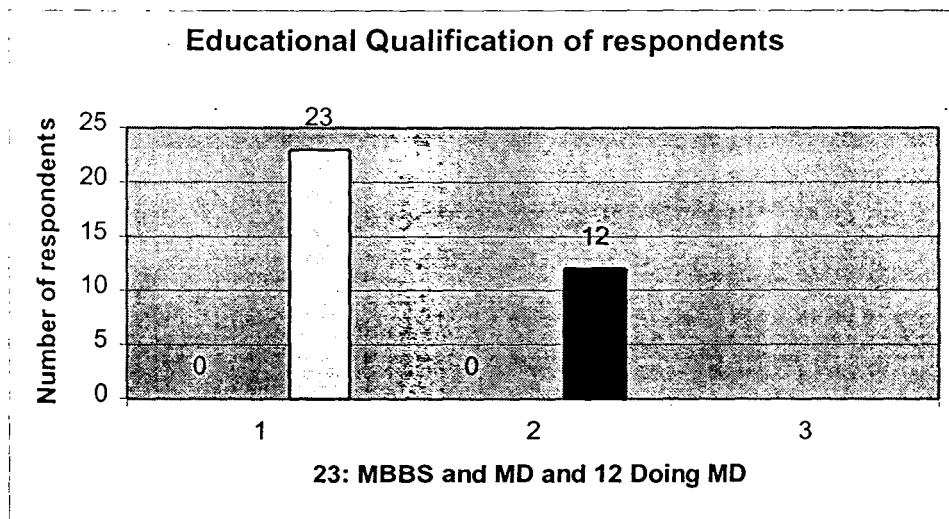


Figure-4.7

4.7 Employment Status:

The employment status of respondents is important to ascertain so that the number of respondents who are in private practice along with government job can be known. Further the results can interpret whether men or women or both can manage private practice along with the government job. The literature survey shows that only men physicians get an opportunity for running private clinics, as women physicians tend to manage familial responsibilities. In this study set of 35 respondents, Figure-4.8 brings out that 31 respondents reported to be in government job and only 4 respondents had private practice set up along with the government job. Also out of 4 respondents who are doing private practice and government job both, 3 were reported to be males.

Employment Status of Respondents

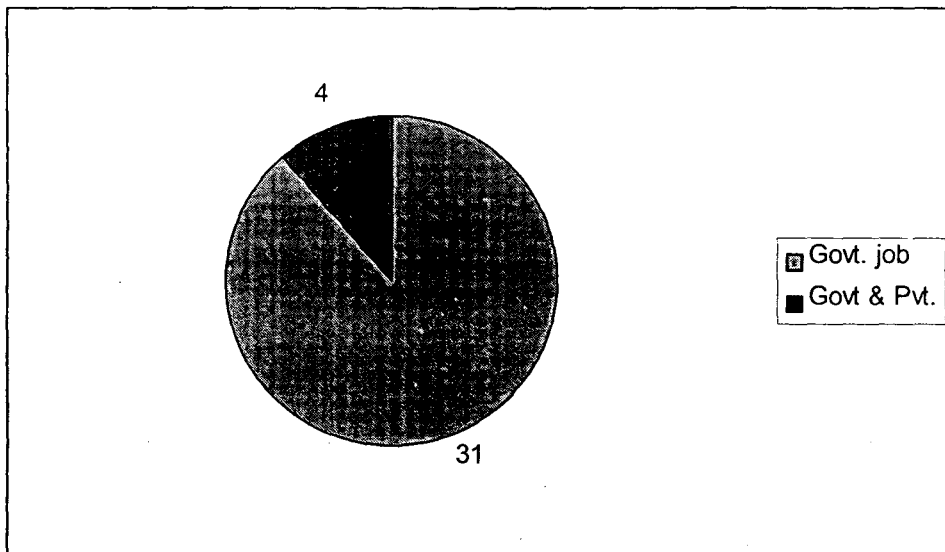


Figure-4.8

Hence supporting the earlier made studies on the subject that men physicians get more opportunities to earn and as well as practice their skill as compared to women physicians.

As regards number of years in service the literature brought to light that women physicians have an unstable career graph as compared to the men counterpart. There is discontinuity is due to marriage and family demands etc. Also, women tend to be in specialties that they can manage along with their family responsibilities. The Figure-4.9 brings out that in the study of six specialties with 35 respondents 10 respondents are in service from last 2 years; 13 from 2 to 10 years; 6 from 10-18 years; and the other 6 are in service from 18 years and more.

Number of years in service

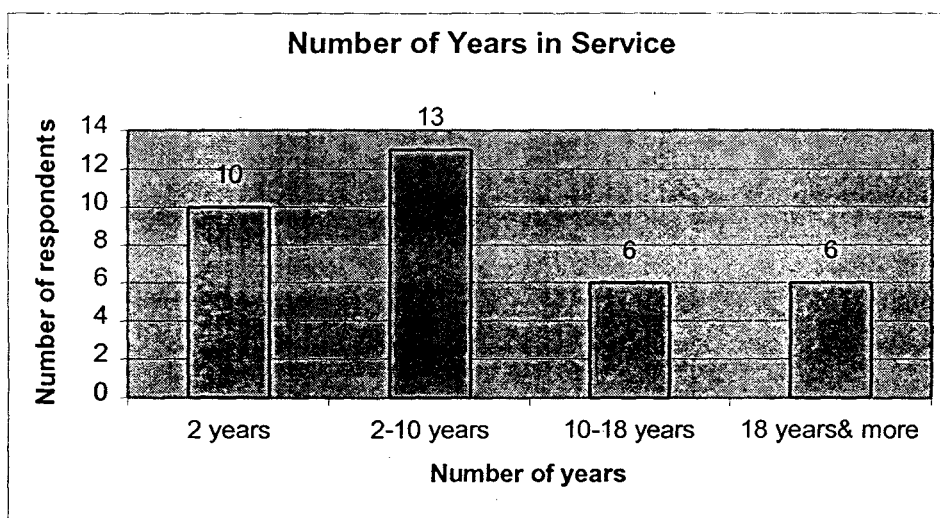


Figure-4.9

Out of those respondents who are in service from last 10-18 years 4 respondents are females and 2 are males. And out of 6 respondents who are in service from last 18 years and more 4 respondents are females.

Though the findings shows that the continuity in service among the women physicians. But the fact that the women respondents are those who are found in specialties that are essentially 'female' dominated cannot be ignored.

Hence the continuity series as seen in Figure 4.9 supports the hypothesis that men physicians move higher up the ladder as and when the career opportunity comes meanwhile the women physicians tend to be placed in the respective job roles for a longer period of time.

In the following section the responses of the study conducted and the codes used are summarized.

Table 4.2 -The Socio-economic & demographic characteristics

	Total	Male	Female
Age:	35	16	19
Above 40 years	13	5	8
Below 40 years	22	11	11
Sex:	35	-	-
Males	-	16	19
Females	-		
Marital Status:	35	16	19
Married	29	14	15
Single	6	2	4
Native Place:	35	16	19
Outside U.P.	6	2	4
U.P.	29	14	15
Family size:	35	16	19
3-4 members	19	10	8
5-6 members	14	4	10
7 & more	2	1	1
Earning members:	35	16	19
1	4	4	0
2	20	9	11
3	8	2	6
4 & more	3	1	2

The Socio-economic & demographic characteristics:

	Total	Male	Female
Edu. Qualification:	35	16	19
Doing M.D.	12	6	6
M.B.B.S. & M.D.	23	10	13
Employment Status:	35	16	19
Government Job	31	13	18
Govt. & Pvt. both	4	3	1
Years in service:	35	16	19
2 years	10	6	7
2-10 years	13	6	4
10-18 years	6	2	4
18 years & more	6	2	4

Hence, to sum up the findings of socio-demographic characteristics of the sample we can say that most respondents are below 40 years of age and hail from the State of Uttar Pradesh.

The fact that most respondents are from UP is stressed as one respondent rightly asserted:

“ In places like UP, Bihar etc where literacy rate is low, people in general are not able to accept female physicians as competent and tend to add as

a pressure group forcing them to go in for the traditional female occupations/specialties.”

Another respondents who supported the above view said that:

“ More of are found in Gynaecology, Anaesthesiology, Paediatrics as these are essentially branded as ‘female’ in character. More so in a place like Lucknow, with a conservative culture, women are accorded less space to opt for specialty of their own choice.”

Hence it can be concluded that the findings are applicable particularly to the State of Uttar Pradesh. The majority of the respondents are in service from last 2-10 years and have nuclear families to support with 1-2 earning members in the family. Also, most respondents are married females possessing degree of MBBS and MD.

Chapter-V

5. Career profile of the Medical Professionals

At the outset, it is important to first know the reasons for choosing the said career and later the given specialty as the former serves as a contextual background for the factors affecting selection of specialty.

5.1 Medicine as a Career

The reasons cited by the 35 respondents for choosing medicine as a career are tabulated in the Table 5.1 given as under.

Table: 5.1 Reasons for choosing medicine as a career

REASON	MALES	FEMALES	TOTAL
Own Preference	15	17	32
Peer Pressure	-	2	2
Family Profession	1	-	1

Medicine as a career

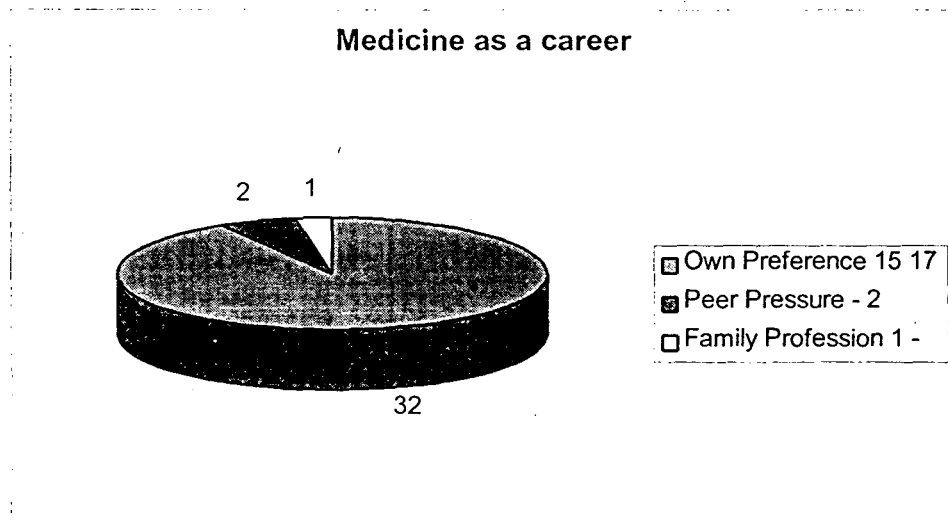


Figure-5.1

As it can be seen in the figure-5.1 and Table 5.1, most of the respondents opt for medicine, as it is their own choice of a career. However two respondents accepted that they selected medicine as a career due to peer pressure. Ironically both the respondents were women. Thus supporting the facts implicit in the literature review that peer groups often influence the choice of a woman. Here it is important to note that the respondent who opted for medicine as a career because it runs in his family was a male.

5.2 Choice Of Specialty

The choice of specialties in post graduation of the 35 respondents is listed in the Table 5.2a given below:

Table: 5.2: Specialty choice of respondents

SPECIALTY	MALES	FEMALES	TOTAL
Anesthesiology	2	7	9
Pediatrics	1	4	5
TB and Chest	-	8	8
Surgery	3	-	3
Neurology	3	-	3
Gyne. & Obst.	7	-	7

There are number of underlying forces which are responsible for making the said choice of specialty by the physicians. The study has argued that these reasons are different for men and women physicians.

The various factors, which operate while making such a selection, were listed in the questionnaire administered. During the informal discussion with the physicians certain responses are also quoted in this section that help support the hypothesis constructed.

5.3 Reason for selecting the specialty:

The Table 5.3 below shows the reason for choosing the said branch of medicine by the respondents:

Table: 5.3 Reasons for selecting the specialty

REASON	MALES	FEMALES	TOTAL
Own Preference	14	17	31
Family pressure	1	1	2
Less no. of hours	-	1	1
More paying	1	-	1

As visible in the above table remuneration offered is an essential criterion while opting the specialty for a male respondent. However a female respondent enlists number of work hours to be the as main reason while choosing a specialty.

It is obvious that to a male physician earning bread for the family is more central than work hours, the latter being essential criterion for a female as she has dual responsibility of looking after family and children along with her career.

The gender roles have ascribed males to be the 'bread winners' and the females to be 'care giver'. The study argues that the gendered division of labour has influenced preferences for career and specialty leading to sex

typing of branches in medicine. The data obtained supports the hypothesis.

5.4 Factors affecting selection of specialty:

During the process of socialization there are certain patterns of gender inequalities, which manifest in adult life. The study has tried to list the factors that affect choice of specialty among the physicians. These factors operate differently for men and women physicians as will be evident from the findings stated below:

5.41 Family members in same profession

As it can be ascertained from the Table 5.4 that compared to men more women respondents have family background of medical professionals

Table: 5.4 Family Members in the same profession

Members in same profession	Male	Female	Total
1-2	7	7	14
3-4	2	4	6
5& more	-	2	2
None	7	5	13

5.42 Same specialty choice as that of family member

Only 22 respondents answered the question as only they had a medical background in their family. The findings in Table 5.5 show that more

women respondents opt for the said specialty that is practiced by another member of the family.

Table: 5.5 Same specialty choice

Specialty choice	Male	Female	Total
Same	2	5	7
Not same	7	8	15

Thus, it can be interpreted firstly that women physicians opt for medicine as a career as they have a history of medico professionals in the family secondly their choice of specialty is influenced by the factor that the same selection has been made by another member in their family.

5.43 Professional Support

There are a number of studies, which state that work environment, and the reaction of colleagues to the professional choice/achievement affect decision of the physician. The absence of informal collegial networks between men and women have made it difficult for women physicians to establish themselves in specialties that are male dominated (Chidambaran, 1993). Therefore the reason for choosing a given specialty is also affected by how the professional hierarchy views the decision of the physicians.

Table-5.6 Reaction of colleagues

Reaction	Male	Female	Total
Compete	5	5	10
Jealous	-	3	3
Sceptical	-	3	3
Encourage	11	18	19

The men respondents who report a competent work environment belong to specialties that have no women. The women respondents who reported a jealous and competent work atmosphere practice specialties that are essentially female dominated or have no males. Thus women have to face competence from two angles whereby men even though found in some women dominated specialties do not consider their skills to be competent enough.

5.44 Family Support

The support and encouragement of family is an important factor in life of a professional. This factor plays a crucial role in life of a woman professional as she has shoulders dual responsibility i.e. of family and her career demands. As compared to a man who has been assigned the role of a 'bread winner'.

In the Table 5.7 are listed the following different reactions by the family to the professional achievements of the respondents—

Table: 5.7 Reaction of Family to achievements

Reaction	Male	Female	Total
Indifferent	1	1	2
Skeptical	-	1	1
Encourage	15	17	32

Ironically only the female respondent reported being looked upon skeptically for her professional achievements. On the other hand all male respondents reported to being encouraged by their family.

5.5 Norm/s restricting choice of specialty

Women's career roles in work outside the home are extensions of their family roles as wives and mothers; tending the sick and caring for children, with an added service component (Nieva and Guteck, 1981).

Similar studies have shown that culture and specialty choice interact in such a way that the physicians select those specialties that blend with the existing cultural norms in the society.

Here it is necessary to quote one respondent according to whom the reasons why women are more segregated in branches such as Pediatrics and Gynecology is this that these branches are "*soft in character*" and "*it*

is easier for women to handle kids as they have been doing the same at their home”.

The Table 5.8 shows that only 3 respondents agree that there are certain norms that restrict their choice of specialty, the rest don't disagree. However the responses contradict the remarks stated by some of the respondents at the end of the questionnaire where they have listed a number of customs posing as placard to their selection of specialties.

Table: 5.8 Norms restricting choice

Reaction	Male	Female	Total
Norms restrict	1	2	3
Do not restrict	15	15	30
Restrict in past	1	1	2

The women respondents reported that there are certain norms such as culture, family pressure and long hours of work that came in their way while taking a decision for the said choice of specialty.

5.6 Perception of respondents:

On certain issues the respondents' perception was recorded as under the following sub headings:

5.61 Meeting career and family demands at same hour.

As seen in the Table 5.9 most of the respondents agreed that due to a taxing career they are not able to meet their responsibilities at same hour.

Table: 5.9 Meeting demands at same hour

Responses	Males	Females	Total
Able to meet	3	2	5
Not able to meet	1	1	2
Not all times	12	16	28

5.62 Family complaints

The opinion of the respondents was sought on the matter and the responses are as under:

Table: 5.10

Family complaints for not meeting responsibilities

Responses	Males	Females	Total
Complains	9	-	9
Not complains	-	14	14
Sometimes	7	5	12

Ironically not even a single female respondent said that her family complains ever of responsibilities. However only 2 female respondents are confident of balancing their roles in family and as well as career.

5.63 Happy with remuneration

The data shows that women respondents are more dissatisfied with the monetary benefits awarded to them as compared to their men counterparts.

Table: 5.11 Happy with pay structure

Responses	Males	Females	Total
Happy	13	8	21
Unhappy	3	11	14

5.64 Change of specialty

The respondents were given an option to depart from practicing the said specialty. The Table 5.12 below brings out that only women respondents were open to the idea and that to only if any incentive would be given for doing the same.

Thereby strengthening the hypothesis that the choice made by the women physicians is conditioned by the work and family environment and not their own preferences.

Table: 5.12 Change of specialty

Responses	Males	Females	Total
Want to change	-	2	2
Do not want to change	16	14	30
Can change if given incentive	1	3	3

5.65 There is sex segregation for jobs in medicine

The opinion of the respondents on the issue was sought giving them the following choices as listed in Table 5.13

Table: 5.13 Sex segregation

Responses	Males	Females	Total
Segregation	7	10	17
No segregation	5	4	9
May be in past	4	5	9

Expectedly most respondents agreed that such segregation does exist. One respondent suggested that the reason behind women physicians not opting for so called 'hard specialties' is this that " *these have anti-social timings or late hours of work, emergency travels and even heavy physical labour as in braches such as Orthopedics*".

Another respondent ardently said, " *Inspite of all big voices on equality, women are still not considered equal to men. Even while making choice of*

career or specialty, the demands of family, societal norms come into play and they are therefore not able to achieve what they are actually capable of”.

The above made statement sums up the analysis of the findings and supports the study hypothesis.

5.7 Results of hypothesis testing:

The findings listed in the Chapters IV and V thus substantiate the hypothesis formulated that there is sex typing of specialties in medicine and limited possibility for women doctors to practice non-traditional specialties.

Chapter-VI

6. Summary And Conclusions

6.1 Summary

The gendered division of labour in health care is a largely neglected topic in the literature on health-care occupations. The contributions of this study primarily describe and have tried to provide an explanation for the position of women physicians. In Chapter-I the concept of gender is employed to draw attention to social processes that naturalize and depoliticize the different positions of women and men in the organization of health care.

The review of literature in Chapter-II brings to light that the women physicians, like other women workers likely to be found in less prestigious, lower-paid work (Coser 1981). Women have access to work in occupations that are not of high priority in commanding economic resources and where the workers are relatively powerless politically; women are restricted in their opportunities for work in occupations or professions that command prestige and high income, and where the workers have control over the conditions and terms of their work.

Medicine's openness to women physicians has varied with the strength of the profession and with the demand for lower cost doctors. Women's supposed prime commitment to family responsibilities justifies restricting their access

to work of higher reward, but they are encouraged to enter the labour force where there is a shortage of male workers. Women's actual commitments, interests, and motivations are of less importance in their patterns of work than their society's need for certain kinds of workers.

The non-competitive, complementary aspect of the division of labour in the family is also reflected in the labour market in the form of non-competing gender groups: feminine occupations in supportive roles and masculine professions in dominant roles (Butter *et al.* 1985).

Historical evidence confirms that all early governance policies and most current public policies have been defined and developed by policy makers who have defined each situation from a male perspective, resulting in a delivery system that favours male patterns of labour market participation and rewards male life cycle activity patterns and perpetuates the gender gap in hierarchy of professionals, while women form the majority of workers in health labour market (Dias, ANM's nurses etc), the description, analysis and especially the interpretation of this market situation have not traditionally taken into consideration the female experiences.

The study projects this in the form of specialty choice made by women physicians. The selection being influenced by more than one ways especially where in a society the position of women as a 'bread winner'

is not even recognized, far less protected or promoted. And when it comes to making a choice for a career, the issue of family demands undermines all possible reasons and avenues of doing justice to career. This aspect has been justified through the Chapter-IV and V where the findings of field study conducted on physicians at King George Medical College, Lucknow are discussed. The salient features of the findings were grouped under the following sub headings:

- Socio-economic and demographic profile of medical professionals: An analysis of the profile of the respondents was obtained by study of these characteristics.
- Career profile of the medical professionals: This section helped in exploring the interaction of various factors responsible for shaping the specialty choice of a physician.
 - Medicine as a career
 - Choice of specialty
 - Reasons for selecting the said specialty
 - Factors affecting selection of specialty
 - Norms restricting choice of specialty
 - Perceptions of respondents

The findings thus brought to light that predominately female occupations continue to have low status in the hierarchy of health occupations, male defined health systems maintain the status quo in inefficiencies included and gender stereotypes are reinforced from one generation to the next.

In overall the study reflects on the lack of organized and complete information on sex typing of specialties in medicine. Also, it points out at the urgent need for evolving a framework that incorporates female perspective while choosing a given specialty so that the selection process is meaningful. It brings to force the need to strengthen the analysis of facts operating while physicians make a specialty choice so that a strategy can be drawn for health manpower planning. It is only thus, that we can set guidelines and put forth policies and programs that meet the need for giving space to women physicians while making a choice of specialty.

6.2 Conclusions

This section is to purpose of this chapter is to comment on different strategies for change that are not only an answer to recognition of numbers but to express gender inequality.

6.21 Strategies for Change

Though it is extremely difficult to fight informal discrimination as an individual. Petty incidents and covert slurs can rarely be confronted outright. The most well meaning people use long standing assumptions about the proper roles and expected behaviour of women and men without recognizing their discriminatory effect. The ideology of equal opportunity, fairness, and merit is accepted at face value, and it is an article of faith that competent and

qualified women will make it as long as they are not are not formally excluded. However this study has brought to light that when they (i.e. qualified women) don't, the blame is placed on their personal choices.

Supposedly, all that is needed to eradicate systematic gender inequality is to find and train more competent, qualified women. As they move through their careers, they will redress current imbalances, and in proportion to their numbers, the best of them will rise to the top.

However, the recognition of numbers alone is not an answer to gender inequality since increasing the number of women in a male-dominated workplace can bring a backlash. As the number of women increases, they have less contact with male colleagues and less support from female supervisors (South *et. al.* 1982 b). Women's confidence in their abilities to succeed and to lead expands with a rise in their numbers (Israeli 1983; Spangler, Gordon, and Pipkin 1978), but men become resistant to their competition and to loss of dominant status (Goode 1982).

The views expressed by the female respondents suggest that if women are to gain positions of power, the patterns of informal organization of the workplace must routinely include them. The findings and analysis clearly bring out that as a group, women must be trusted as colleagues, sponsored for

advancement, given recognition for competence and accomplishment, and accrue the resources and reciprocal favours that advance careers.

6.22 Emphasizing gender to undercut gender

Women must be prepared to fight the system of gender discrimination for a long time. Gender inequities are pervasive and long standing because they are built into social institutions and maintained by everyday assumptions about appropriate work for women and men in and out of home.

The hierarchical nature of relations between men and women is reflected in subordinate status in many aspects of women's life in family and society. The analysis of women's work, their role in family and society reveals the secondary status of women in family society and economy. Thus studies argue for incorporating women in new development paradigms reiterate the need for inclusion of gender as a parameter in development analysis because there has been a systematic failure in conceptualization and application of development in relation with its differential access and impact to the life of men and women.

Questions have to be raised as to the ultimate goal of advancing women as a group, or to put more women into positions of power in existing institutions, or to change the structure of institutions and their values and practices to reflect women's special perspective.

Gender discrimination cannot be countered by citing individual examples and studies of women physicians in their careers, or shared responsibilities at home. Personal solutions are vital for individuals to survive, but it takes concerted, politically sophisticated group action to restructure deeply embedded social arrangements.

The ultimate goal should not lead women to join men in inner circles imbued with the male perspective on work, family life, and social service, but should be to strive for the establishment of new values which reflect the needs and priorities of all members of society-female and male, old and young, rich and poor.

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