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### **Continuity and change in the gender segregation of the medical profession in Britain and France**

by *Rosemary Crompton*, Professor of Sociology, City University, London, U.K. and *Nicky Le Feuvre*, Senior Lecturer in Sociology and Gender Studies and Director of the Interdisciplinary Research Centre at the University of Toulouse-le-Mirail, France

#### **Abstract**

It is a well established fact that the entry of women into higher-level professional occupations has not resulted in their equal distribution within these occupations. Indeed, the emergence and persistence of horizontal and vertical gender segregation within the professions has been at the heart of the development of a range of alternative theoretical perspectives on both the 'feminisation process' and the future of the 'professions' more generally. Through an in-depth comparative analysis of the recent changes in the organisation and administration of the medical profession in Britain and France, this paper draws upon statistical data and biographical interviews with male and female general practitioners (GPs) in both countries in order to discuss and review a variety of approaches that have been adopted to explain and analyse the 'feminisation' process of higher-level professions. Our conclusions review the theoretical debates in the light of the evidence we have presented. It is argued that, despite important elements of continuity in respect of gendered occupational structuring in both countries, national variations in both professional and domestic gendered architectures lead to different outcomes as far as the extent and patterns of internal occupational segregation are concerned. Both female and male doctors are currently seeking—with some effect—to resist the pressures of medicine on family life.

#### **Introduction**

The entry of women into previously male-dominated occupations such as medicine raises a series of issues of interest to social scientists and policy makers. Past discussions of women's entry into medicine have tended to be dominated by a model of gender exclusion, reflecting the *actual* exclusion of women from prestigious occupations since their initial emergence as identifiable groupings in the nineteenth century (Witz 1992). These formal barriers have been largely removed, but nevertheless, intra-professional occupational segregation is still widespread. In part this reflects the persistence of masculine exclusionary practices—even though these are likely to be informal rather than formal in nature. However, patterns of occupational distribution within professions also reflect the (re)production of the gender division of la-

bour within the professions as well as in the wider society.<sup>1</sup> Women still retain the major responsibility for domestic and caring work, and as we shall see, the intra-professional distribution of medical specialties in both Britain and France reflects this.

The increase in women's levels of employment is associated with a number of social trends and societal changes. Contemporary theoretical discussions emphasise the growing significance of lifestyle choices and identities in 'reflexively modern' societies. Some commentators have interpreted these trends as evidence of a growing individualism reflecting the marketisation of ever more areas of social life (Giddens 1992; Giddens, Beck and Lash 1994; Beck and Beck-Gernsheim 1995). An emphasis on the significance of individual choice is also found in Hakim's (2001) contentious argument that women are clustered in family-compatible feminised niches within occupations and organisations because the majority of women—even the well-educated—'choose' to put their family lives before their employment careers.

However, we shall argue that, rather than simply focus on the individual, it is important to examine the national, contextual and institutional implications and outcomes of changes in the gender division of labour of which the growth of women in the professions is but one aspect. The entry of women into occupations from which they were previously excluded—such as medicine—not only has implications for the profession and its practitioners. In a wider context it also impacts on state policies relating to the organisation and delivery of health care, as well as the national 'gender context' within which these changes are taking place. In this paper, therefore, we will explore the implications of the changing division of labour between men and women, both within the medical profession and also within 'work' in its wider sense, with reference to general practitioners (GPs) in Britain and France.

'Work' involves not only paid work but also domestic labour, which can often intermingle with paid work (Glucksmann 2000).<sup>2</sup> Patterns of market 'work' cannot be comprehensively grasped and understood without reference to patterns of unpaid domestic and caring work. By convention, women have assumed the major responsibility for this unpaid work but increasingly, women are participating in market work and (although to a lesser extent) more men are participating

in unpaid domestic work (Sullivan 2000). These generalisations, of course, obscure the very wide variations in the distribution of market work and domestic labour between households, and between individual men and women in different countries. In comparison to Britain, the French state (and French employers) has historically offered more support to families, particularly in respect of childcare, and this has been associated with a higher level of full-time work amongst French women (Hantrais 1990). The contrasting organisation and delivery of healthcare in France and Britain also has consequences for the way in which doctors in Britain and France organise their 'care time' and 'working time', with rather different outcomes for the internal differentiation of the medical profession in the two countries.

In this paper, our object will be to shift the terrain on which discussions of 'women in the professions' have been situated. Previous discussions have tended to focus on women and men as *categories*, with a corresponding emphasis on the individual or collective effects of 'masculine' or 'feminine' behaviour within the profession. Whilst maintaining a focus on the individual, in this paper we will also emphasise the *context* within which individuals are located. We will see that universalistic theories relating to topics such as 'women' and 'the professions' need to be tempered by an appreciation of the sensitivity of these concepts to their national and local contexts.

### Doctors

Medicine was once the epitome of a male-dominated, high status, profession (Witz 1992; Davies 1996). Medical training is long, and so, by tradition, are the hours worked by doctors, especially whilst in training positions in a hospital setting. Nevertheless, in nearly all industrialised countries, women are now the majority of those training in medicine. However, comparative research on women's entry into medicine in Britain, France and Norway has shown that, despite the increase in women's representation in the profession, they are still largely absent from some male-dominated specialties such as surgery. Perhaps even more importantly, women tend to cluster in those specialties in which it is possible to achieve some control over working hours (Crompton, Le Feuvre and Birkelund 1999). Thus the medical profession remains male dominated, and women are not represented in the most prestigious specialties in their due proportion.

In our recent comparison of the employment and domestic trajectories of doctors and bank managers in Britain, France and Norway (see Crompton 1999), we found that women doctors, despite being gender pioneers in their chosen profession, were nevertheless rather more likely to be relatively conventional as far as their domestic arrangements were concerned. They also tended to have more children than women bankers. We explained this tendency with reference to the capacity of women doctors to select, if they wished, professional options that gave them some control over their working time. This might mean either working less than full-time (whether salaried or self-employed), or choosing a specialty with regular and predictable hours of work.<sup>3</sup> Most women doctors had made these choices whilst still in training, in the expectation that they would assume the major responsibility for any future home and family—which they did. These choices reproduce somewhat conventional gender roles in the home and reinforce the sexual division of labour within the profession.

Our subsequent interviews with male doctors suggested that most male doctors with children had partners who took the major responsibility for childcare and domestic arrangements. However, we interviewed three male doctors (one in each country studied) who had *chosen* to share childcare with their wives. In each country, their approach to their careers and decision-making was very similar to that of the women doctors who had chosen their specialties in order to mesh an employment and family ‘career’—although the career options chosen by family-oriented male medics were different in each country. In Britain, general practice had been chosen, whereas in France, the doctor was in a salaried position. As this paper will show, this difference is a significant one. The biographical information given in the table below makes a very simple point. If male doctors give priority to family compatibility when making their occupational decisions, then they will ‘choose’ options similar to those ‘chosen’ by like-minded women. Thus, the career consequences of caring responsibilities, whether conventionally imposed or freely chosen, will be the same for both sexes.

In this paper, we will be focusing on general practitioners in Britain and France. In both countries, GPs are self-employed independent contractors. However, there are important differences in the delivery of primary health care in the two countries (Crompton and Le Feuvre

Family-oriented male doctors		
Britain	Norway	France
<p>Born: 1966, married, 3 children (1994, 1995, 1997) GP: part-time partner</p> <p>Childcare: during training used nursery, now shared equally with wife who also works part-time. "In my view, family's more important than work—and in my view, if there is a balance there—if you have to go home to your family then ... you have to go home to your family and someone else will carry the can."</p>	<p>Born: 1964, married, 2 children (1994, 1996) GP: municipal health centre</p> <p>Childcare: alternating emphasis with wife, he took extended childcare leave (6 months, 18 months) to be full-time carer. "I chose general medicine, largely on account of my family. I have better work times now, and fewer night calls ... I work only with women here—they understand my family needs...my ambitions are less important now."</p>	<p>Born: 1959, married 2 children (1989, 1992) Salaried <i>médecin du travail</i></p> <p>Childcare: shared with wife. "In my family life my wife and I are interchangeable, when the children were young we each did every other night, we each did every other weekend, there is no doubt that we have reached equality between the sexes ... I'm a bit of a nonconformist and traditional family life really gets on my nerves." Moved job (to salaried) because of children.</p>

1997). In Britain, GPs are remunerated by the National Health Service (NHS) according to a complex formula that incorporates an amount for each patient registered with their practice. Joint practices are prevalent (70% of all GP practices have two or more doctors) and doctors do not receive a fee for individual patient consultations. In France, on the other hand, patients are not required to register with a particular GP or GP practice and doctors receive a fee for each consultation. Joint practices are less common than in Britain. Given the high density of medical practitioners in France<sup>4</sup>, particularly in urban areas, competition between GPs for patients is widespread (Hassenteufel 1997; DREES 2001c).<sup>5</sup>

### **The British case**

In Britain, the great majority of qualified doctors work either in hospitals (either in training positions or as specialists in particular branches of medicine), or in the community as GPs.<sup>6</sup> Doctors working in hospitals are salaried, although specialists often carry out private practice on a fee basis, in addition to their work for the National Health Service.

Although GP principals are self-employed, as a group they have resisted competition (between individuals or between different practices) and have drawn heavily on the ideology of 'professionalism' in their contractual negotiations with governments. In the case of medicine, as Shuval and Bernstein have argued, 'professionalism' involves an: "...all-encompassing devotion to work characterised by total personal involvement that focuses on the intrinsic rewards of work, transcends the monetary rewards and spills over to invade the professionals leisure time leaving little space for extra-occupational concerns" (cited in BMA 1998).

In the 1950s, the translation of this ideal into general practice in Britain was expressed as follows: "...the essence of general practice is to live amongst your patients as a definite cog in the whole machine, knowing them so well in both health and sickness, and from birth until death, that [...] the patient is so familiar to his family doctor that he of all people can be in the best position to give an accurate diagnosis, prognosis and treatment most suitable to the patient's way of life" (cited in Lewis 1997).



The stereotype of the dedicated professional, working very long hours, was, therefore, once commonplace in general practice, as well as in hospital medicine. The language of professionalism was prominent in the negotiations surrounding GP contracts up until the early 1990s. GPs strongly resisted the idea of a salaried service, as they claimed that this would compromise their autonomy as professionals. Indeed, as Lewis (1997:14) has argued, they sought to use the status of independent contractor to protect professional values, rather than as a means of securing a more business-like contract. In 1965, GPs in Britain drew up a Charter that emphasised professional standards and professional autonomy, and mass resignations from the NHS were threatened unless their demands were met.<sup>7</sup> These demands were accepted by the government of the day.

The claims to professionalism amongst GPs were also a reflection of the unease, in this section of the medical profession, concerning their status in relation to hospital consultants (specialists), considered by many to represent the apex of the medical profession. Indeed, within the profession the GP's representatives followed a classic 'professionalisation' strategy, promoting the relative importance and significance of primary health care, and advocating and developing vocational education within general practice (Lewis 1997:19).<sup>8</sup> In the 1980s and 90s, however, the conservative government of the day sought to bypass these professional claims and to increasingly approach GPs as independent contractors—which, of course, they had always been in any case.

A series of government papers in the 1980s advocated good practice allowances, the contractual specification of services to be provided by GPs, increasing patient choice, and the promotion of competition by giving patients the right to 'shop around'. These proposals were furiously debated and some modifications achieved, but in 1989/90 the then Secretary of State (Kenneth Clarke) imposed a new contract on GPs that made doctors more accountable, gave patients more choice, encouraged competition and made pay more performance related. These changes to the GP contract were taking place at a time when the NHS itself was being reorganised along quasi-market lines. As Lewis has summarised this recent history: "Historically, GPs have seen negotiations over their contract as a means of defending professionalism, but in the 1990s the contract has become seen by govern-

ment as part of a move towards the introduction of market principles and thus as an instrument for securing greater efficiency, quality, choice and accountability” (Lewis 1997:30).

During this period, the numbers of women training for and entering the medical profession was steadily increasing. A disproportionate number of women have always chosen to specialise in general practice and in 1998, women were 58% of GP registrars (i.e., GPs in training, e.g. Sibbald and Young 2001). One reason for the choice of general practice amongst women is that, as independent practitioners, GPs have been more able (than hospital doctors) to control their working hours. There is a direct parallel here with the situation in France, where women are over-represented amongst salaried and independently practising specialists for the same reason (Crompton, Le Feuvre and Birkelund 1999). Recent developments in general practice have further improved the capacity for control over working time by GPs. There has been a substantial increase in group practices and the use of deputising services (paid out-of-hours cover by locums). Since 1995, GPs have been encouraged to enter into out-of-hours co-operatives, which dramatically reduce the amount of time ‘on call’ during weekends and evenings. In 1998, personal medical services (PMS) pilots were introduced, which include GP salaried posts involving less administration and increased clinical content. ‘NHS Direct’—a government-funded help-line for minor illnesses—was also introduced in the same year.

A number of parallel processes, therefore, were under way in general practice during the 80s and 90s. There has been a shift in emphasis away from the ideology of vocationalism, and more emphasis placed on the GP’s status as individual contractors. Patients have become more critical of their doctors—a trend that Sibbald and Young attribute to “... the rise of consumerism within society which has made patients more demanding ... and less respectful of medical professionals” (Sibbald and Young 2001:3). Perhaps in response to the increased emphasis upon their contractual status, GPs have themselves sought to put a limit on their working hours and the extent of their contractual obligations.

As noted earlier, women are over represented amongst GPs in Britain and it would be widely accepted that an important reason for

this is the control of working time that can be achieved in general practice. For example,

“I decided after I married and was doing house jobs that I didn’t want to stay in the rat-race that was hospital medicine... so I decided that, as I wanted to have a family, I would become a GP so that I could work part-time.”

Britain, female GP, born 1949, married (consultant), 3 children

“In the end we both [husband and respondent] decided to do general practice because we thought that we would stand a better chance of staying together... I didn’t want a family and no medicine. I was determined I was going to do both, so I kept on thinking: how can I do both, how can I do both?”

Britain, female GP, born 1958, married (GP), 3 children

Family considerations, therefore, loom large in the ‘lifestyle choices’ of doctors entering general practice in Britain. Our interviews indicate that male GPs also stress the importance of giving space to family life that general practice offers. For men and women, other life-style choices may also be involved in making an occupational choice:

“There are lots of other things I wanted to do with my life than just work and it became obvious that general practice would be the way that I would be able to work part-time and fit in all the other things I wanted to do.”

Britain, female GP, no children

“I did six months in general practice... I didn’t like the idea of doing on-call for the rest of my working career, so I looked at hospital medicine... Then I had the career crisis, so I thought I’d better have another look at general practice, which I did do. I realised there had been changes in general practice. Most places at that point had out-of-hours covered.”

Britain, male GP, 1st child expected

Of course, many GPs, particularly those in sole practice, do work very long hours, and complaints about workloads associated with governmental bureaucracy are legion. Nevertheless, doctors in general commented on changing attitudes to time commitments in medicine:

[Speaking of interviewing new partners] “They want to work less than full time, quite a few of them, if they could. They don’t want to be on call. They don’t want to work bank holidays, etc. etc. They would rather take less money and do less work.”

Britain, male GP, born 1953, married (GP), 2 children

Contractual changes, together with changes in the attitudes of patients and within society more generally, have all, without doubt, had an impact on attitudes to medicine as a 'vocation', with its emphasis upon a long hours and its work-centred culture. It is also very possible that an (unspecified) part of this shift in time preferences is a consequence of the increase in the employment of women doctors, who still bear the major responsibility for their families. They might therefore be anticipated to have more of a stake in the increase in flexible, shorter hours, working.

Detailed figures on the number of hours worked are not available for doctors in Britain. What evidence there is, however, suggests that GPs, on average, work shorter hours in Britain than in France, and that the trend is downwards. The Doctor and Dentists Remuneration Review (1991) reported that in 1989–90 GPs spent an average of 41 hours a week on general medical services (GMS) and six hours on non-GMS activity. An additional 26 hours were spent on-call. In 1998, the Review Body on Doctors' and Dentists' Remuneration reported that GPs averaged 39 hours per week. It should be remembered that these data do not include hours spent on-call, but, as we have seen, our information suggests that this is the area in which the most effective time reductions have been achieved in the recent past. These figures will also include part-time GPs, so the *actual* hours worked by full-time GPs in Britain will be greater than those given here.<sup>9</sup>

In line with these figures, our interview data suggests that amongst GPs, time is often valued more than money by both women *and* men. This is confirmed by a UK survey that reported that 91% of GP registrars saw having leisure time as the most important factor in their career choices, and another survey of GP leavers that found that the most important reason (after retirement) for leaving a GP principal post was that more personal and leisure time was wanted. The significance of this reason did not differ between men and women (Young et al. 2001). There has been an increase in the proportion of male doctors seeking part-time employment. In 1999, amongst applicants for part-time GP Principal posts, men represented 60% of all applications for job-shares, 46% for half time and 63% for three quarter time posts—although they were not recruited in due proportion to their applications

and are still more likely to enter full-time posts (Sibbald and Young 2001).<sup>10</sup>

Non-principals (i.e., locums, assistants, retainers) form an increasing proportion of the GP workforce, and a survey of all GPs qualifying in 1986, 1991 and 1996 showed that the proportion of non-principals rose from 22% in 1986 to 45% in 1996 (ibid:21). A recent study of GP leavers showed that, although women were more likely than men to reduce their job commitments to meet family responsibilities, the "... most striking result of their study [was] not the difference but the similarity among men and women GPs" (Lees et al. 2001).

### The French case

As in Britain, GPs represent about a half of the total medical profession (49%) in France. However, as we shall see, in France it is widely recognised that being a GP (*omnipraticien*) offers limited opportunities for part-time work without substantial financial penalties. Because of the long hours worked by *omnipraticiens*, French women doctors have been historically under-represented in general practice (Herzlich et al. 1993) and have tended to specialise more than their male counterparts and to work either in a hospital setting or as independent practitioners in *cabinets de ville*. This has often been explained by the fact that, in some particularly highly feminised specialties (medical gynaecology, dermatology, etc.), being on-call at weekends can generally be avoided.

Figures for 2000 show that 72% of all French GPs are in private practice (DREES 2001a:3). The remaining GPs are employed in public or private hospitals (15%) or in Community and Public Health Medicine (13%). Women make up 36% of all GPs, but only 27% of those in private practice. Although only 28% of French GPs (as against 50% of all doctors) are in salaried positions, women make up almost 60% of this category. They represent half the GPs working in hospitals and two-thirds of those in Community and Public Health Medicine (DREES 2001a:3). Of the self-employed GPs, only 39% work in joint practices and female GPs are even less likely to belong to a joint practice (35%) than their male counterparts (40%) (DREES 2001a:3). In addition, joint practices tend to be smaller in France than in Britain.

French GPs declare the longest working hours within the French medical profession (an hour a week more than specialists in private

practice, three hours more than hospital based specialists and almost four hours more than non-hospital based salaried specialists). (DREES 2001b) Thus, many French GPs work very long hours, often to the detriment of family life:

“The whole of family life is organised around my profession and my wife complains about this often enough. The practice is in the house, and work necessarily comes first. Last Sunday was my daughters 16th birthday and we had arranged a celebration, I was just in the kitchen opening the oysters, someone knocked on the door and I was gone for half an hour and my daughters were very angry.”

France, male *omnipraticien*, born 1956, married (part-time nurse),  
2 children

Furthermore, avoiding general practice is often cited as a strategy for gaining some kind of control over working time by male and female doctors in France. This can be illustrated by the case of a male GP who, under pressure from his second wife, decided to take a full-time salaried position in occupational health (*médecine du travail*):

“As far as my personal life was concerned, I left the prison of general practice for the castle of occupational health: one could play sports, go out, I was free to have all the leisure time I wanted and that I hadn’t had during the time I was a GP. That’s what occupational health is about, it doesn’t take more than 8 hours a day of your time.”

France, male salaried occupational health doctor, born 1942, twice divorced, 4 children

“As a woman, I couldn’t imagine becoming a GP, because I thought that it was alright for a man to be on call day and night, but, although at the time I didn’t have a family, I thought that that would come eventually and that it would be much better to be a specialist, to be able to consult by appointment only.”

France, female radiologist, born 1957, divorced, 1 child

It is important to remember that although the long hours and other time constraints on GPs in France are widely recognised, this does not mean that doctors are not generally in a position to choose medical specialties that enable them to control their working hours.

“There are numerous possibilities in medicine for anyone who wants to reserve some of their time for family life. I don’t think its incompatible, it just requires more organisation, working in a group practice and it’s totally feasible.”

France, male *anigiologue*, born 1965, married (doctor), 1 child

Nevertheless, the latest figures from a recent study of doctors self-declared working time in France suggest that the average length of their working week has actually increased over the past 8 years—from 48 hours per week in 1992 to 51 in 2000. During this time, there has been no reduction in the difference in doctors' working time by sex. Women doctors consistently work 6 hours a week less than their male counterparts. The length of their average working week has thus increased in the same proportion as that of male doctors. However, 25% of women doctors work part-time (as against 2% of the men). Part-timers work 29 hours a week on average. Thus, full-time doctors work 16 hours a week more than part-timers (DREES 2001b).

French doctors have increased their weekly working time by an average of 21 minutes per year since 1992. This increase has affected almost all categories of doctors, even the most feminised. Women full-time salaried hospital doctors now work an average of 4 hours a week more than they did in 1992 and even 5 hours a week more when they are in non-hospital salaried posts. Even full-time women GPs have increased their working time to an average of 50 hours a week, although the increase for full-time male GPs has been more spectacular—from 55 hours per week in 1992 to 58 in 2000 (DREES 2001b).

### **Explaining Franco-British differences**

Here, we are faced with an apparent paradox. In both countries, doctors are aware of the possibilities of controlling their working hours but, whereas British doctors would seem to be taking advantage of these possibilities, in France working hours in the medical profession are increasing. Additionally, whereas in Britain general practice is regarded as the sector of the medical profession where it is easiest to control one's hours, in France this is not the case. We would suggest that a major factor that explains these differences is the contrast between the delivery of health care in the two countries.

As noted above, whereas in Britain rates of consultation have no direct effect on the level of GP remuneration, in France these are crucial.<sup>11</sup> The revenue of French GPs depends entirely on their ability to attract and retain patients. Thus, only by increasing the number of con-

sultations, particularly those that command the highest fees, can income levels be raised. This leads to widespread competition between GPs.

“Oh yes, there is a feeling of competition, a very strong feeling, there always has been, but I was particularly aware of that during the first five or six years of the practice, much less so now, because I have a pool of patients who keep coming back and others who I never see again, so that doesn't really matter any more.”

France, male *omnipraticien*, born 1952, married (full-time nurse),  
1 child

In the days before the NHS, British doctors were in a similar position of competition for fees. For example, a British GP who had taken over his fathers' medical practice vividly recalled the time when his father ridiculed him for not charging a patient a fee for a prescription for the contraceptive pill:

“Oh my God, you're giving things away, you've lost a fee there, my boy. You youngsters have got no idea at all.”

Britain, male GP, born 1946, divorced (remarried) 3 children

Of course, some GPs in France may decide to reduce their consultation hours and/or to refuse to do home visits or out-of-hours consultations, but they are then likely to earn much less than their colleagues:

“For the out-of-hours consultations, I'm involved in an informal pool, there are four of us and we get on very well together, there were three men originally and they asked me to join them. When one of us has a problem, the others are there to help out. It's very useful in the evenings. It's true that we see things a bit differently, because they are all men, they have families to support, whereas I'm a doctor because that's what I enjoy. If I ever decide that I've had enough, I know that I can just shut the practice, because I have my husband and with his job we would be able to manage anyway.”

France, female *omnipraticien*, born 1958, married (computer engineer), 3 children

“...there are some female GPs who work in joint practices and adopt a particular mode of working. I know one who doesn't do any home visits for example. She is married to a doctor so she doesn't have any financial problems and she organises herself accordingly. She does the odd consultation, a bit of psychology, and plays at being a high-class childminder [i.e. to *her own children*].”

France, male dermatologist, born 1956, married (teacher), 2 children



In both countries, therefore, doctors can choose work and career options that allow them some control over the family-employment interface. General practice clearly offers reasonable opportunities for time sovereignty in Britain and women are proportionately over-represented in this area of health care. In France, on the other hand, women (and men) who wish to control their working hours will tend to gravitate towards independently practising specialties where patient demands can be controlled (such as dermatology), or towards salaried positions.

### Discussion and conclusions

To return to the issues raised in the introduction, we would suggest that when looking at the possible consequences of the feminisation of the medical profession, it is not sufficient to refer to the behaviour of 'women' as such as the primary explanatory factor for gender segregation within the medical profession—either as potentially transforming the professional ethos from within (Davies 1996) or as reproducing the gendered medical hierarchy through their 'choices' (Hakim 2001).<sup>12</sup> There is considerable internal diversity within the medical profession in each country, and indeed, doctors have been identified amongst those occupations most able to take advantage of reflexive 'postmodern lifestyles' (Taylor and Field 1997, cited in BMA 1998).

As individuals in possession of considerable human capital resources, doctors have more power than most other occupational groups to make choices about which job slots they will occupy. However, as we have illustrated above, men and women doctors make these choices within the context of specific constraints and opportunities.

In particular, we have argued that when both male and female doctors make their career decisions, they most frequently do so with simultaneous reference to their actual or anticipated employment and family arrangements. Thus, it would be misleading to describe these kinds of career decisions as straightforward expressions of their *individual* life-style preferences (Giddens 1992).

In both of the countries studied here, women's career aspirations are increasing. Thus, the improvement in women's educational levels, their rising economic activity rates and their access to the economic and social resources offered by a medical career are undermining their

willingness to devote significant proportions of their working life solely to the domestic sphere. These changes, along with the general decline of the underpinnings of the 'male breadwinner' model in both these countries, are making it increasingly problematic for male GPs—and indeed, for professionals generally—to maintain the traditional one dimensional, 'vocational' relationship to their medical careers.

However, the actual outcomes of these changes are not identical in the two national contexts. We suggest that this is in part because the overall contours of the gendered division of labour in France and Britain are somewhat different. Although French women have a more extensive history of full-time, continuous employment than their British counterparts, French men's participation in the domestic sphere is, if anything, below that of British men. This has been explained by the fact that French men have been able to avoid increasing their domestic participation because of the historic and relatively high level of state support for working mothers in France (Gregory and Windebank 2000; Crompton and Le Feuvre 2000). Indeed, Windebank (2001:287) has suggested that: "... the greater flexibility in labour markets and traditional lack of state support in Britain is leading to a more equal gender division of domestic labour in [Britain] than in [France] because both partners need to be involved in caring for children in order to liberate the labour power of the woman".

In Britain, the opportunities for time sovereignty offered by the development of group practices, deputising services and salaried practice, have made it possible for GPs to achieve some control over their work levels according to the other potential demands on their time. In the absence of external time management resources, the adoption of shorter working hours has become a common strategy for male and female GPs. They have not necessarily had to accept a significant drop in income to do this, given that the larger part of their income depends on the number of patients registered, rather than the number of consultations achieved. At the same time, the British male doctors who can rely (or who choose to rely) on the availability of their spouses for child-care and home management are more likely to gravitate towards the most 'time hungry' sectors of the medical profession, in this case, hospital medicine and the most prestigious specialties such as surgery.

Indeed, it could be argued that a national context (such as France) characterised by a long history of state support for child-care combined with the more recent development of subsidised domestic services to high income households (Le Feuvre and Parichon 1999) actually places less pressure on individual medical practitioners to reduce their working time. In combination with the competitive nature of general practice and the more direct relationship between working time and income, these societal characteristics are conducive to a distinctive time management polarisation of the medical profession along gender lines. Because of the competitive environment in which they work, French GPs find it harder to strike a balance between maximising their income through long working hours and enhancing their 'time sovereignty'. Our evidence suggests that, contrary to the British case, the men and women who enter private practice as full-time GPs in France are those in a position to transfer most of their domestic responsibilities to a third party. This is usually a spouse, who, with potential support from the state-funded child-care and domestic services, may not necessarily have to abandon the labour market completely in order to fulfil this task. Thus, although the societal context means that women doctors in France can adopt relatively continuous employment profiles without having to mobilise too much of their partners' time, this strategy requires them to cluster in those sections of the medical profession where 'time sovereignty' is most easily achieved. This is evidently the case in salaried positions (as hospital GPs or specialists) and in certain private practice specialties, but much less so in full-time GP practice.

It therefore follows that, although aggregate levels of occupational feminisation might appear as very similar in different countries, national variations in professional and domestic architectures may lead to different outcomes as far as the extent and patterns of internal occupational segregation are concerned. In France, the 'fee for service' system for GPs goes a long way towards explaining the long hours worked by *omnipraticiens*. However, following the argument developed by Gregory and Windebank (2000), the extensive childcare support historically provided by the French state may serve to alleviate the pressures put on male doctors (principally by their working wives) to reduce their working time in accordance with family and domestic demands. This second consequence is obviously more likely to reinforce

the pattern of the 'gender arrangements' (Pfau-Effinger 1993; 1999) of French GPs along 'modified male breadwinner' lines. In the British case, it is hospital medicine, particularly at consultant level, that offers the most restricted contextual opportunities for the adoption of 'time sovereignty' strategies and that is, therefore, the most conducive to the exclusion of women and to the replication of a 'modified male breadwinner' model of gender relations amongst the hospital doctors.

Finally, we would argue that individuals with substantial occupational power, such as the doctors discussed in this paper, are able to devise their own ways of combining employment with caring and family life, and, as we have seen, this is the case for both men and women. Particularly in the case of the British GPs, such individuals would indeed seem to be in the process of constructing their 'reflexive biographies' in ways that can impact on and re-shape the institutions within which they are making their choices. However, their ability to do this will nevertheless depend on the opportunities available within a particular professional context in a given country. Furthermore, it must be stressed that individuals with this level of power—women and men—represent only a small minority of all national populations.

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**Endnotes**

1. Some authors have suggested that as more women enter the professions, then 'professionalism' itself (which is claimed to be essentially 'masculine') will be transformed as a direct consequence of feminisation (Davies 1996). For a critique of this approach, see Crompton, Le Feuvre and Birkelund 1999.
2. Glucksmann describes this as the 'total social organisation of labour' (TSOL). This concept "... refers to the manner by which all the labour in a particular society is divided up between and allocated to different structures, institutions, activities and people" (Glucksmann 2000:19).
3. In fact, because of the different manner in which medical services are organised in the three countries, the particular specialties chosen varied.
4. In 1999, France had a medical density of 331 doctors per 100 000 inhabitants, as against 175 in Britain in 1997 (DREES 1999:2 and DREES 2001c:6).
5. Patients are free to consult any number of GPs or specialists in the same week (or even day) and to have the consultation fees reimbursed through the Social Security system. Recent government attempts at curbing health spending in France, which involved 'capping' the number of consultations and making individual doctors pay back any fees received in excess of their targets have been strongly resisted by the medical profession.
6. In Britain, 45% of doctors are in hospital medicine, 50% are GPs, and the remainder work in Community and Public Health Medicine. These figures do not include junior doctors in training.
7. The majority of GPs submitted undated resignations which were held by the BMA.
8. In fact, recent developments within medicine in respect of diagnosis and treatment (for example, of diabetes), have strengthened the clinical position of GPs.
9. Hospital doctors work much longer hours. A survey of 515 Senior House Officers found that 60% worked more than 56 hours a week and 15% typically worked 80 hours or more. Following the EC Directive



on Working Time, the NHS is currently engaged in measures to reduce the hours worked by hospital doctors.

10. The BMA 1995 cohort study of medical graduates showed that 58% (of which 47% were men and 53% were women) believed that doctors deserved a decent family life and leisure time, and 29% (of which 46% were men and 54% were women) thought that the practice of medicine must be organised in a way that allowed doctors to balance their family and other interests. Only 1% (3 men) believed that medicine was a vocation (BMA 1998).

11. As is, of course, the consultation fee that each type of doctor can charge patients. This is defined annually by the Ministry of Health, in consultation with the professional representatives on the board of the Social Security system. A higher consultation fee is negotiated for home visits and out-of-hours consultations. Doctors retain the right to charge patients more than the legal fee ('*dépassement d'honoraires*'), but these extra fees only represented 6% of GPs income in 1998, as against 12% of the annual revenue of French specialists (see DREES 2000:7).

12. For a critique of these perspectives, see Le Feuvre 1999.

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