Women's career success and work-life 'balance' in the accountancy and medical professions in Britain

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GeNet Working Paper No 26

August 2007

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Introduction

It is a well-established fact that, from the 1960s and 1970s onwards, women in Britain have substantially increased their levels of qualification relative to men. In particular, in the 1970s, and even more rapidly in the 1980s, increasing numbers of women began to qualify for higher-level professions such as medicine, law and accountancy (Crompton & Sanderson, 1986). This increase in qualification levels amongst women took some time to work its way through the occupational structure. For example, in the 1980 Women and Employment survey (Martin & Roberts, 1984), only twenty-six of the over five and a half thousand women in the sample were employed as professionals – a number too small for statistical analysis. However, over the last two decades women have become firmly established in managerial and professional occupations and by the year 2000, although still under-represented as compared to men, women comprised over 30 per cent of all managers, and 40 per cent of all professionals (Dench et al., 2002).

This improvement in women's occupational positioning has been accompanied by important legislative and normative changes. Since the 1970s, Sex Discrimination and Equal Opportunities legislation has been consolidated, and as the then Chancellor Gordon Brown noted in his 2005 pre-budget statement, paid employment for women and mothers is now accepted as a 'fact of modern life'. The paid employment of women with pre-school age children in the UK rose from 48% to 57% between 1990 and 2001 (Dench et al., 2002). Of these, the proportion of professional and managerial women in paid work (81%) is significantly higher than women in other occupational groupings (Walling, 2005). Nevertheless, despite this evidence of employment

continuity, in aggregate, even highly qualified women do less 'well', in occupational terms, than similarly qualified men (Devine, 1994).

In the discussions of the 1980s, there was a cautious optimism that women would be enabled to use the 'qualifications lever' (Crompton & Sanderson, 1990) in order to achieve successful careers. This optimism was to some extent a consequence of the fact that, in the 1980s, contemporary empirical researchers had argued that deficiencies in women's 'human capital' (to which a lack of education and qualifications made a major contribution) were a major factor contributing to occupational segregation (Chiplin & Sloane, 1982). Nevertheless, this optimism *was* only cautious, and qualified by an appreciation of the likely persistence of gendered stratification in both paid and unpaid (i.e., domestic and caring) work. In respect of employment, it was suggested that gendered 'occupational niches' would develop within higher-level occupations (Crompton & Sanderson, 1986). That is, that, even when similarly qualified to men, women would tend to cluster in those areas of professional employment that meshed well with their domestic obligations.

There can be no single explanation for the apparent 'underperformance' of women in professional and managerial occupations, even when at similar levels of qualification to those of men. In the 1980s and 1990s, much attention was focused on direct and indirect male exclusionary practices that effectively blocked women's progression through the occupational hierarchy (Kanter, 1977; Davidson & Cooper, 1992). In respect of these practices, anti-discrimination legislation has had a considerable impact, and overt discrimination by sex has become relatively unusual (Bradley, 1998). However, it has by no means disappeared altogether, and recent evidence (as

well as a number of high profile court cases) suggests that the ‘old boys’ network’ still persists, even in ostensibly gender neutral organizations (Wass & McNabb, 2006).[1] Another major reason for women’s lack of career success is that women, even when in full-time employment, usually retain the major responsibility for caring and domestic work (Harkness, 2003). Thus although women (and men) in professional and managerial occupations receive better work-life entitlements from their employers (the ISSP 2002 survey found that 64% of managers and professionals, as compared to only 38% of routine and manual employees, enjoyed ‘good’ work-family entitlements (Crompton et al., 2003a: 175)), many women do not feel able to take advantage of these entitlements, particularly if they wish to pursue a career (Crompton et al., 2003b). Qualified women who take advantage of flexible work opportunities, such as part-time work, often do so in the full knowledge that their employment careers will be negatively affected.

Doctors and Accountants

In this paper, we will explore these issues via a comparison of women’s (and men’s) career development in two highly qualified occupations: medicine and accountancy. Both occupations require considerable investments in training and qualification in the early years. The increase in the proportion of women qualifying as doctors was already very apparent in the 1970s and 1980s, and in 2007, women were the majority of those qualifying in medicine. The increase in women qualifying in accountancy was from a much lower initial level (in 1975, only 7% of new members of the ICAEW (Institute of Chartered Accountants in England and Wales) were women, as against 34% female new entrants into medical schools), and was only really marked

from the 1980s (Crompton & Sanderson, 1986). ICAEW membership data shows that in 2004, 26% of chartered accountants were women. This percentage was much higher in the younger age groups, at 38 % of those aged 31-35, and 47% of members under 30.

As qualifications, both medicine and accountancy might be seen as having a number of advantages as far as women are concerned, in that they are 'occupational' rather than 'organisational' (Crompton & Sanderson, 1986) qualifications. Those possessing occupational qualifications will usually find little difficulty in moving from job to job – for example, as a consequence of geographical mobility – and re-entry to employment after a career break is eased. As Elliott et al. have demonstrated in their longitudinal analysis of the National Child Development Study, 'Occupationally specific qualifications…enable women to retain a closer attachment to the labour market during (the) period of family formation, and in addition would seem to protect women from the drop in earnings typically associated with taking time out of the labour market or working part-time' (Elliott et al., 2001: 163).

A major difference between medicine and accountancy, however, is that in Britain, medicine is essentially a public sector profession – although many hospital doctors undertake private work, and General Practitioners (GPs) are self-employed. In contrast, accountancy is overwhelmingly a private sector occupation – in 2004, only just over 7 per cent of ICAEW accountants worked in the public or non-commercial sector, 52% worked in business or industry, and 41% in private accountancy practices. Another major difference between accountancy and medicine is that whereas both professions are client based, the relationship with clients is very

different in the two professions. In both professions, the client is reliant on the professionals' knowledge and expertise. However, the power relationship between a doctor and his or her patient is very different from that between accountants and their clients – who will often be other profit-oriented organisations. Clients of accountants in business, industry and practice are paying customers with a sense of entitlement that often results in considerable demands being made of the professionals (accountants) in their employ.

The data sources on which we draw are both quantitative and qualitative. We were granted access to the ten-year cohort study conducted by the British Medical Association (BMA).[2] This study has tracked the careers of a representative sample of doctors qualifying in medicine in 1994. It is an extraordinarily rich source of data, but numbers for which information is available for all years are rather small, at just over 400. For the accountants, we were given access to the 2004 Institute of Chartered Accountants in England and Wales (ICAEW) membership survey.[3] In the ICAEW survey, there are over thirty thousand available responses, but only a limited range of variables are available (in particular, there is no data available on part-time working). In addition, we have carried out work-life interviews with twenty doctors (eight men and twelve women, interview quotes denoted as M) and twenty accountants (ten men, and ten women, interview quotes denoted as A), all with children under fourteen).[4]

One of our major foci will be on career development, for men and women, in these two professions. All of these men and women are highly qualified at the outset of their careers, and in this important respect they start out on an equal footing. However, are career paths similar for men and women, and if not, at what point do

gender differences begin to emerge? What factors affect career development? Is sex discrimination still an issue, or are the differences we describe more a consequence of the normative domestic constraints experienced by women, particularly when they have children? To what extent do women 'choose' 'family-friendly' employment options, and is it possible to work part-time and still have a 'career'? As we shall see, the opportunities and strategies available are rather different in medicine and accountancy, and in our conclusions, we briefly reflect on the implications of these differences for policies oriented towards gender equality.

Career choice and development in Medicine and Accountancy

Figure 1: Changes over time in choice of medical specialty (Source, BMA cohort study).

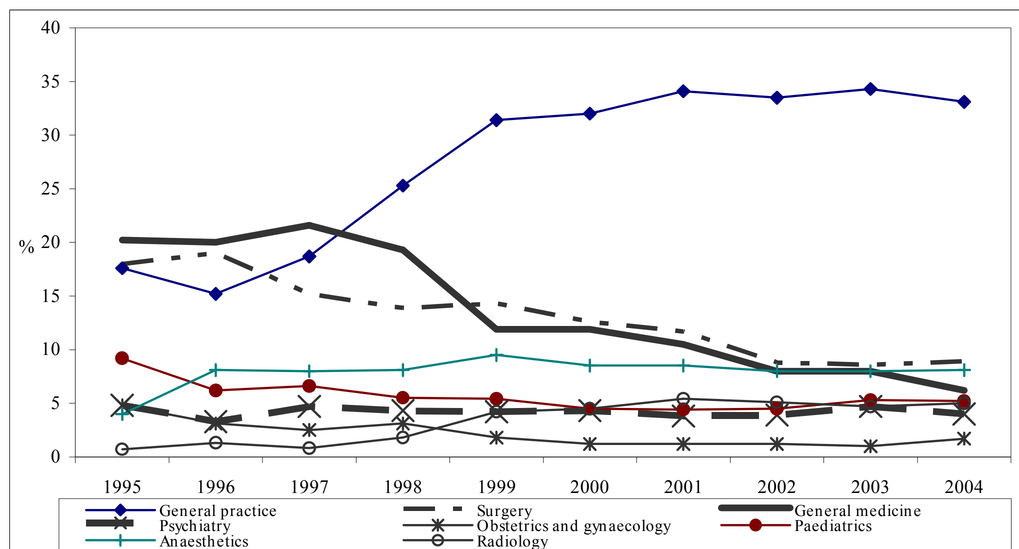

Figure 1 (men and women) shows that over the decade after qualification in the mid 1990s, the numbers of qualified doctors choosing General Practice (GP) increases substantially, whilst the proportion choosing hospital-based specialties (particularly

surgery and general medicine) decreases. However, as we can see from Table 1, there is a substantial gender bias in this pattern of career choices. Using the longitudinal data available, we classified the BMA respondents into four categories: those who were consistent in their choice of hospital medicine, those who were consistent in their choice of general practice, those who had changed to hospital medicine from a GP choice since qualifying, and those who had switched to a GP choice from a hospital choice since qualifying.[5]

Table 1: Doctors: Career choice over time by sex (source, BMA surveys).

	Always hospital	**Always GP**	**Change to hospital**	**Change to GP**	**Total**
Male (%)	110 (62%)	16 (9%)	26 (15%)	25 (14%)	177 (100%)
Female (%)	50 (31%)	39 (25%)	18 (11%)	52 (33%)	159 (100%)
Total (% of all)	160 (48%)	55 (16%)	44 (13%)	77 (23%)	336 (100%)

Table 1 demonstrates that not only do more women indicate general practice as their consistently first career choice, but also that a third of women doctors changed to general practice as a first career choice over the period of the study. General Practice is a specialty well known within the profession as being 'family friendly' (over two thirds of new GPs are now women). Indeed, women GPs are significantly more likely

to have children than women in hospital medicine (as, indeed, are male GPs). Women are also more likely to work part-time. However, although GP work is 'family-friendly', within the medical profession, it is seen as being of lower status than hospital medicine.

We did not have longitudinal data available for accountants, but an analysis by age groupings enables us to compare the career trajectories of men and women. We divided the ICAEW respondents into three categories, high (partner/director/chairman) middle (managers/section head) and low (non-managerial employees. Self-employed sole practitioners are not included, as are accountants working overseas, and those on a career break). Table 2 demonstrates that even in the 31-35 year age group, men are significantly more likely to have achieved partnership or directorship status than women.

Furthermore, marriage carries with it a promotion and wage premium for male accountants, but marriage (or being single) has no such career advantages for female accountants.[6] Whether married or in a partnership, or single, on average female accountants are in lower occupational positions than married or single men. Our evidence, therefore, suggests a "hierarchy" of career attainment, where partnered men do best, followed by unpartnered men, then women (either partnered or unpartnered). For those women in the youngest age groups, things might be changing for the better However, significant gender differences in attainment are apparent from the age of 30 onwards. When we looked at the effect of the presence of children in the household, similar results were shown: men with children did best, followed by men without

children, then both women with and without children least likely to reach the highest levels.

Table 2: Current job status of qualified accountants by age, men and women (ICAEW data)

	Partner/director/ Chairman		**Manager/ Head**		**Non-managerial Employee**		**Total n**	
Age	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
< 30	3	2	50	48	47	51	2076	1833
31-35	20	10	64	67	16	23	2820	1745
36-40	50	27	42	58	8	16	3448	1501
41-45	65	35	29	48	6	17	3462	1198
46-50	73	43	21	40	6	17	3220	679
51-65	73	42	20	39	7	19	5839	393
65+	84	n/a	10	n/a	6	n/a	212	1
Total n (%)	11432 54%)	1488 (20%)	7138 (34%)	3893 (53%)	2507 (12%)	1969 (27%)	21077 (100%)	7350 (100%)

There are, therefore, significant differences in levels of occupational attainment between men and women in accountancy, despite their equal levels of qualification at the start of their careers. However, we found, in some contrast to medicine, not very much evidence of sex segregation *within* the accountancy profession. The proportion of men and women working in accountancy practice is the same (41% of men and 41% of women). More men than women work in business and industry (53% of men

compared with 47% of women), with a correspondingly higher proportion of women than men working in the public or non-commercial sector (12% of women compared with 6% of men). Although the higher proportion of women working in the non-commercial sector might have been anticipated (women in general are more likely than men to express a preference for a job where they can 'help other people', see Crompton & Lyonette, 2006b), our data did not suggest a particularly disproportionate 'clustering' of women in particular sectors of the accountancy profession.[7]

In both medicine and accountancy, therefore, women do less well than men in career terms. In medicine, women are clustered in the lower status specialty of General Practice, and, despite the increase of women in the profession, only 4% of surgeons, and a quarter of hospital consultants, are women (Roberts, 2005). In short, our evidence indicates the clear emergence (as suggested in Crompton & Sanderson, 1986) of 'gendered niches' within the medical profession (see also Crompton, Le Feuvre & Birkelund, 1999). The ICAEW data has graphically illustrated the differing career trajectories of men and women in accountancy. The two professions present an interesting contrast as far as gendered career outcomes are concerned. Within medicine, General Practice may be regarded as less prestigious, but it is as well paid as hospital medicine (the average GP salary is now over £100,000). This is in some (large) part a consequence of the organising and bargaining capacities of the doctor's professional body (the BMA). Thus although the profession is, increasingly, internally stratified by sex, the 'feminised niche' within medicine is well-paid, and the relative earnings of female doctors have been maintained, despite the feminisation of the profession (Rubery & Grimshaw, 2006).

Accountancy does not offer a similar ‘family friendly’ professional niche such as General Practice. Accountants work in a highly competitive commercial environment, and, as we shall see, the ability to work long hours is seen as essential to career development, and working part-time is regarded as a serious barrier to a professional career. In the absence of a ‘family-friendly’ occupational niche, qualified accountants with caring or domestic responsibilities, therefore, have to decide on their own, individual, within-family, work-life options. In the light of these broad differences between the two occupations, in the next sections we will draw on our interview data in order to explore in more detail the occupational processes that contribute to these contrasting differences in gendered occupational achievement.

Careers in Medicine and Accountancy: the interview data

Given the nature of the project, those willing to be interviewed tended to be particularly interested in ‘work-life’ issues. Despite their high-level jobs, many of our interviewees were very ‘family’ oriented and respondents and their partners had made considerable efforts, and sometimes sacrifices, in order to achieve a work-life ‘balance’. Family strategies had sometimes involved fathers ‘downsizing’ their career development, as well as mothers. We are aware, therefore, that our interviewees represent a somewhat atypical ‘sample’ of doctors and accountants. Nevertheless, our interviews suggest considerable differences between the two occupations in their management of work-life articulation, particularly in respect of working hours. These differences reflect the specific occupational opportunities and constraints that we have illustrated via our quantitative data.

All of the women we interviewed were in employment, although some male interviewees had non-working partners. However, as a general rule, the women we interviewed (and the female partners of the male interviewees), took the major responsibility for the organisation of childcare and domestic work, even though this was often 'bought in'. For example:

> We have frequent rows about that, but I have to say they're not like horrendous disagreements, just (husband) always thinks we can pay the way out of it by getting someone else to do it and you can't sort of get someone else to interview your au pair and interview your nannies for you and that kind of thing (*A3, Female accountant*).
>
> I mean the week before [last] was really bad because he *(son)* had diarrhoea and vomiting and they *(the nursery)* refused to take him in. So they called me up on the Monday, which was my day…on duty, my husband was in training so there was no way he could come out, so I had to go and pick him up from nursery, bring him back to my work, where the receptionists were very kind and took it in turns to look after him while I finished off on duty. The following day I was also on duty and there was again no way my husband… (*M20, Female GP*)

Domestic responsibilities, therefore, still remain an issue for most women, and, as our quantitative data has suggested, will have an impact on women's career choices and development. Next, however, we will briefly examine the persistence of male exclusionary practices within the organisation. As we have argued in the introduction to this paper, these practices have become less overt, but nevertheless, our interviews revealed evidence of continuing gender discrimination:

> *(reasons why she was turned down for a promotion this year)…* I'm not into the old boys' system, I'm not popular with the powers that be, and once I got to London I had no mentor, women lacked mentors and I've never …shmoozing with the big wigs, I've never been able to shmooze, I've not been able to mingle with the male medical aristocracy, or the powers that be *(M18, F consultant).*
>
> There are still quite a few, not all old, but quite a few men who come from a particular culture, who have certain views about things should be. And I don't think that's going to change very quickly. And I think that there will be lots of

> people, men and women there who started out with partners who have careers, but women have found it more difficult to carry on with the career, so the men there will be leading lives where their partner is at home looking after the kids, so that's what they know. And there will be expectations about difficulties of women working with children, because there will always be problems, kids sick or something (*A18, F accountant*).

One of the female accountants interviewed had brought a sex discrimination case against her employer, but the out of court settlement (which was substantial) had included an agreement that barred her from discussing the case. Our interview data, therefore, *did* reveal evidence of gender discrimination in both medicine and accountancy. Whilst not wishing to minimise the importance of such discrimination, however, it does seem to be rather less systematic and widespread than that revealed in earlier research (Witz, 1992; Crompton & Jones, 1984). However, and shifting the basis of our argument rather, we would argue that in aggregate, the major factor contributing to the gendered, and unequal, outcomes for women within the medical and accountancy professions is the fact that women still assume the major responsibility for caring and domestic work. These normatively assigned responsibilities mean that women face considerable difficulties in building a professional and/or managerial career (and it should be noted that men who take on domestic responsibilities will face similar difficulties). In medicine, however, there is available a 'family-friendly' 'occupational' work-life strategy (the GP route), within which a career can be built. In contrast, in accountancy, women appear to face a starker choice, that is, between 'going for a career', or remaining at a lower occupational level.

Working hours in medicine and accountancy

Not surprisingly, empirical research has demonstrated that long hours working is a major problem as far as work-life 'balance' is concerned (White et al., 2003; Moen (ed.), 2003; Crompton & Lyonette, 2006a). In this section, we draw on a series of question prompts in our interviews in which respondents were asked about their working hours, whether they could work from home, and whether they could reduce their working hours.

Recent changes to GP contracts have allowed GP practices (which are owned by the partners) to opt out of on call and weekend working. In addition, many practices arrange matters so that partners can have a free day a week (although this might mean working longer hours on the other four days). As one female GP who works eleven hour days, but only three and a half days a week, explained:

> That's how come we end up having a day off, a day and a half off you see, we try and fit everything…the way the surgery's worked out is we have a set amount of work we have to do in a week, number of patients, paperwork that kind of thing and then it's up to the partner, up to the individual how they fit it in in that week. And the way I've done it is I fit it in the three and a half days so that I get a day off, so that on that day off I will take maybe X out of nursery and things like that and pick up Y, you know, it's my little day to myself and things like that (*M20, F GP*).

Similarly, a male GP partner:

> I have a contract with my partners to deliver a level of service to our six thousand patients and we're paid for that, we're paid in equal terms to do that and everything else but I say forty-four hours a week, I actually work slightly under that… now I have one full day off which is great and I don't even think about work at all during the whole day *(M15, M GP).*

GPs, therefore, have achieved a considerable degree of control over their working hours, and the 'average' length of the GP working week is 35 hours (this includes,

however, part-time working). However, some hospital doctors work very long hours, especially during training. Consultants, too, can work long hours, [8] and some consultants work longer hours because of private practice, which is very lucrative:

> I mean technically I'm doing forty-four, though some of that is flexible time which I can do at home or whatever, and say ten hours a week of private work. *do you work more than your contracted hours?* No, no, I make sure I don't. *(M13, M consultant)*

In general, consultants tend to work shorter hours than those in training. As a female SPR (in training) explained:

> Once I finish my PhD, I would like to go back to a more normal (working hours)…And I'll be senior enough not to have to do first on call. *Right. Is that how it works then?* Once you get to be a consultant, your salary is not predominantly dependent on doing out of hours *(M4, F SpR).*

Most of the consultants we interviewed, however, did not work excessively long hours:

> *How many hours a week do you normally work?* 40 and I do just 40. *Okay, and over how many days or nights is that?* Five days *(M5, M consultant).*

And as a female consultant said:

> …almost anything is possible. In medicine, actually jobs are fairly flexible *(M8, F consultant)*.

In summary, young doctors do work long hours in training (although hours in training have been brought down considerably, due to the efforts of the BMA as well as legislative changes such as the European Working Time Directive), but once qualified, hours can be brought under control. As we have seen, many doctors (particularly women) will take the 'family friendly' GP option, but even in hospital medicine, senior doctors are, increasingly, taking control of their working hours. As a

female consultant, working a 40-hour contract with one day a week off when she is simply 'not available' said:

> …when you do it to start with (leaving at 5 o'clock), you know, you get a few eyebrows raised but I've just kind of decided not to feel bad about it because actually there is no reason why I should have to work past five o'clock, and it's a very unhealthy culture they expect people to stay and work beyond their hours as a normal thing *(M9, F consultant)*.

In contrast, in accountancy there is not an occupational career option, such as General Practice, that facilitates shorter hours working. Most accountants who wish to control their hours do so by becoming self-employed, often part-time (GPs are also self-employed). Some of our interviewees had indeed done just this.

> *Do you plan to reduce your hours at all?* No, I'm quite, it's fine. My main, personally, my main priority is to just be home after school, so as long as I can work - I mean, the maximum I could obviously do then is 9 'til 3 every day, and probably only four days so I've got one day to do all the things which, you know, or if they come under, like if it's somebody's birthday or something, I have all those responsibilities as well. So that would probably be the most I wanted to work, about 20 hours a week I think *(A8, F accountant, self employed).*

Working part-time

Obviously, self-employed accountants have considerable control over their working hours - and some parallels might be drawn with general practice here - but they are only a small minority of accountants. Qualified accountants working in organizations can negotiate part-time work, but this is often seen as rather problematic. Some accountants (usually women) who had negotiated part-time work nevertheless found themselves working considerably longer hours than contracted:

> …my contract is 28 (hours), what I actually do is nearer 36, even on a normal week, and might be even more if I have, particularly if I go abroad, it can be very long days. When you do Gibraltar in a day it's quite a…*Do you do a lot of travelling?* Off and on. I mean, I've had a lull for the last year but the year before that I did a huge amount of travelling including, as I say, Gibraltar in a

> day. That was a five o'clock in the morning start and a one o'clock the following morning get back *(A1, F accountant).*

Women who had negotiated a four day week still found themselves doing a full week's work, although this could be made up by bonuses:

> *Are they paying you less? (for a 4 day week)* Not much. My basic has been taken down accordingly but in banking, your basic only makes up about a third of your salary, another two thirds comes in an annual bonus. *So your bonuses will stay the same?* They stay the same because, as my boss says, I'm doing the same amount of work which just means I don't take lunch hours, I don't go round and gossip so much because I'm busier in the four days I'm there *(A3, F accountant).*

However, one problem with moving to a shorter working week was that this was clearly seen as a disadvantage in career terms:

> I mean the trouble with doing four days a week is, you know, your career profile changes very dramatically when you do that and, you know, you just don't get the same opportunities in your career that you do if you're working full time. *Even at four days a week you think?* It shouldn't happen but it does, and that's one of the reasons I chose four days and not three because it's still 80% of a job, and it even used to choke me to describe it as part time to be honest…I know there are at least two jobs during my last eighteen months at X that I wasn't considered for even though I had really good experience, because they wanted definitely five days…And this was even me with a good track record of delivering *(A12, F accountant).*

Moreover, in some contrast to the doctors who could 'switch off' or were 'not available' on the days when they were not working, it seemed to be expected that accountants who worked part-time would still be available when required:

> *Do you get called at home and things like that, normally?* Yes, sometimes, or I quite often get someone sending a text message, can you look at, deal with this. *(A 10, F accountant)*
>
> …if something comes up they'll ring me or they have my home email *(A14, F accountant)*.

These kinds of pressures were seen as inherent in the nature of the job:

> ….a lot of it is about building relationships and networking, and if you're always absent a lot, you're not present in the office, I honestly don't think it (shorter hours) would work *(A12, F accountant)*.

Moreover, senior staff were definitely seen as having to 'set an example':

> *So you feel it's important as the manager that you…?* I think it's important to be seen to be there. I think it's, they can get quite down, you know, … and fairly sort of demotivated if you see your boss sort of disappearing, not working late, disappearing off early, it can be quite demotivating. And the fact of the matter is I have got things to do so I'm usually around with the crew *(A5, M accountant).*

Our interviews suggest, therefore, a self-reinforcing long hours culture in accountancy: '…the 'good' accountant is defined as one who is willing to prioritise work at all time' (Lewis, in press). Moreover, the long hours culture is closely bound up with promotion possibilities. As we have already seen, part-time work is seen as career limiting, and promotion to higher levels (in some contrast to medicine, see M4 above) is seen as requiring even longer hours of work:

> It's much more (being a partner), there's a bit more pressure, certainly when you are bottom level because there is a big pressure for developing business, so it's like you have your own little business, so you would be judged on your results. So if your results aren't good, if you're not going out there winning work, you would soon be spotted, you would suffer financially, ... And it would not beyond the firm to get rid of that partner *(A17, M accountant).*
>
> Well that's one of (the reasons for being uncertain about promotion), because it would probably mean working longer hours. *Is that something you've seen or is that something that's been specified?* No, it's just something you see…*But it's more the actual hours that would be the difficulty?* It's more the hours and actually because you'd then be started as a very junior partner, someone would say want to meet at eight o'clock in the morning, you'd have to say yes that's fine…And big hierarchies and there's a lot more dinners and internal management stuff which are all done out of (working time) *(A10, F accountant)*.

Qualified accountants, therefore, seem to find it difficult to control their working hours, even when they opt for part-time work within organisations. It would seem that the only realistic strategy they have available is an individual one – that is, to become self-employed – and only a minority takes this route. In medicine, the contrast between hospital medicine and general practice emerged again over the question of part-time work. Senior doctors (consultants) can control their working hours without loss of status (see M9 above), but others argued that going part-time might mean not being 'part of the team', or losing vital skills:

> …a lot of the time the part-time posts are just waiting list initiative, you know, they need somebody to see this number of back pains or this number of people with such and such, whereas a full-time post, you're part of the team, you're setting up a service or doing something a bit more meaningful. So it would be difficult to get the equivalent post as a part-time person, I think. *(M11, F Specialist Registrar, PhD).*
>
> …it's very easy to say you want to go part time. Do you drop the on-call? If you drop the on-call you lose your neonatal skills. If you lose your neonatal skills, you're not an equivalent paediatric anaesthetist. It isn't just a simple issue of doing fewer hours….in my mind if I went part time I would need to still do the on-call in order to have equivalent skills and possibly (same) status as your colleagues. *(M14, F ex-consultant).*

In contrast, loss of status by switching to part-time work would not seem to be a problem for GPs:

> I would say that women are much more likely to have career breaks with things like maternity obviously, but… once you're a GP and a partner within a practice then everybody is actually on an equal footing. *So for women they take time out, say up to six months, they could come back quite easily?* Come back in where you were, yeah, absolutely. *Without any sort of penalty in terms of career?* No. No, none at all, no. In hospitals, that's different I think. It shouldn't really be but I think it still is to a degree. *(M1, M GP).*

Discussion and conclusions

In this paper, we have compared gendered career paths, working practices, and work-life strategies in two rather different professions, which are both high status and highly paid. We have seen that in both professions, gendered differences in career development emerge at an early stage – in the late twenties and early thirties. The nature of these differences, however, varies between the two professions. In medicine, women tend to choose a family-friendly occupational route, whereas in accountancy, women 'fail' to rise through organisational hierarchies at the same rate as men. In both professions, sex discrimination is still to some extent an issue, but our interview data suggests that the major factor contributing to these gendered career differences is the adaptations that many women feel they have to make in order to accommodate their domestic responsibilities.

A number of our interviewees (including some men) had chosen to work part-time. However, and particularly in accountancy, part-time work was seen as seriously career limiting, even when accountants worked 'long' part-time hours. Moreover, there was evidence that 'part-time' accountants in organisations worked longer hours than contracted, and were also expected to be 'on call' on their 'free' (and unpaid) days. In contrast, (and without wishing at all to minimise the pressures of the long hours worked by doctors in training), our interviews with doctors, male and female, suggested that they had been able to 'take control' of their working hours once a certain point in their career development had been achieved (see M20, M13, M5, M9 above).

As described in the introduction to this paper, these are two rather different professions, although both require high levels of qualification, and both are ‘feminising’. However, a major contrast is that medicine is a predominantly public sector occupation, and accountancy a predominantly private sector occupation (it should be noted, however, that considerable efforts have been made by government to develop a ‘quasi-market’ in health provision). Another contrast that may be drawn between the two professions is in the nature of their professional organisations. Indeed, we would suggest that the case of medicine in Britain suggests that the role of a powerful professional body (the BMA) has been key to the absorption of large numbers of women without either occupational ‘downgrading’ (Reskin & Roos, 1990) or declining pay.[9] The BMA has played a successful campaigning role in reducing the hours worked by doctors,[10] as well as in contract negotiations with the doctors’ major employer – the government. These negotiations have ensured that part-time employment in medicine is not significantly disadvantaged, and that all medical specialties, whatever their relative status, are well-paid.[11] In contrast, the ICAEW acts largely as an accrediting organisation, rather than as a representative body for the membership as a whole, and does not seek to regulate working conditions. Individuals working in accountancy can earn very high salaries (36% of men working in accountancy practice earned over £100,000 a year in 2003), but in the highly competitive working world of chartered accountancy, individuals have to make their own adjustments to work-life pressures.[12] Such adjustments are likely to be career limiting, and even ‘part-time’ employees work longer hours than contracted. As those making these adaptations are likely to be women, individual women are more likely to lose out, in career terms, in accountancy than in medicine.

Both medicine and chartered accountancy are well remunerated, and feminising, occupations. However, aggregate evidence on pay also suggests that relatively speaking, women do 'better' in medicine than in accountancy. For example, LFS data indicates that whereas women doctors maintained their relative pay advantage (over other female full-time employees) up to 2005, that of female chartered and certified accountants declined, whereas male chartered and certified accountants actually increased their relative pay advantage over other full-time men (Rubery & Grimshaw, 2006).

What wider lessons may be drawn from this comparison of two feminising professional occupations? The increase in the employment of women (particularly mothers), together with their increasing levels of education and qualification, has brought the topic of work-life conflict, and its resolution, to the forefront of national and international debates (COM, 2001; HM Treasury, 2003). It may be suggested that our occupational comparisons present, in microcosm, two, rather different, solutions to these 'problems'. The regulation of employment conditions within the medical profession has certainly facilitated the absorption of increasing numbers of female doctors. However, there is extensive gender segregation within the medical profession. As we have seen, women are coming to predominate in general practice, and are still massively under-represented in the more prestigious specialties, such as surgery. Nevertheless, although the medical profession is increasingly segregated, women in 'gendered niches' are well paid.

Here a parallel might be drawn between the medical profession in Britain and the national policies developed by countries such as Sweden and the Nordic countries in

response to the entry of women into the labour force. Not only is the labour market in Sweden (relatively) highly regulated, but the Swedish state has facilitated extensive welfare supports for dual-earner families. As a consequence of these policies, the level of occupational segregation in Sweden is high (women predominate in the public sector, and in the jobs created by the states' provision of caring facilities). However, the gender wage gap in Sweden is relatively low.

The second 'solution' to the increasing employment of women is to ensure individual rights in respect of gender equality (as in, for example, the USA), but to eschew 'collective' solutions such as employment regulation, or the state provision of dual-earner supports. In such a context, (and again, the USA provides a good example here), some individual women may do very well (for example, there are relatively high rates of women in management and in the upper levels of academia in the USA, and relatively low rates of occupational segregation), but the consequences for the 'losers' are more severe. Indeed, the extent of material inequalities in such societies is considerable (Gornick & Meyers, 2003). Nevertheless, there is a body of evidence and debate that suggests that in aggregate, women do 'better' in less regulated labour markets (Soskice, 2005).

Here a parallel may be drawn with the occupational experiences of accountants. Individual accountants (men and women) may do very well, but the competitive pressures of the work environment present considerable difficulties as far as the reconciliation of a successful career and work-life 'balance' is concerned. Our interviews suggest that those who make the necessary adaptations – and these could be men or women - tend to 'lose out' more than those making parallel adaptations

within the medical profession. The accountancy profession, lacking in 'gendered niches', is not, however, as highly segregated as the medical profession in Britain.

Our comparison of these two occupations, therefore, has raised some fundamental questions as to the optimum manner of adaptation to the entry of women, particularly highly qualified women, into employment. Is the answer re-regulation, and the creation of 'family-friendly' jobs, so that those with caring responsibilities can continue in employment? Or is it more important to secure individual rights and opportunities? There can be no straightforward answers here, although our interview evidence does suggest that as an occupation, medicine is less afflicted by work-family tensions. However, the crowding of women into family-friendly occupations, and/or family-friendly niches within occupations, will not only reproduce occupational sex segregation, but also might have little impact upon the gendered division of labour in its wider sense – which includes women's normative responsibility for domestic and caring work.

Nevertheless, it is important to remember that the work of caring is gender *coded,* rather than 'gendered' in any essentialist sense, and that men can care, as well as women (Fraser, 1994). Thus men, as well as women, can take up 'family friendly' employment options, and our interview data provides a number of examples. As we have noted above, the BMA cohort data indicates that male GPs were significantly more likely to have had children than male hospital doctors, and interviews with male GPs suggested that giving priority to family life had been an issue for them as far as their career choices in medicine were concerned, as well as for those of women doctors. Wider patterns of normative change (such as men wanting to spend more

time with their children, for example), might result in more men opting for family-friendly employment.

We cannot predict whether gender norms and associated behaviours will or will not change in this direction. However, in order for this to happen, a 'choice' has to be available, and as we have argued in this paper, in the competitive world of the accountancy profession, the 'choices' available are rather stark. For there to be real equality, and capacity for choice, in respect of careers for men and women, would require a set of far reaching transformations. These would include: universal state policies to support dual-earner families, a more equal sharing of caring and domestic work between men and women, as well as a reduction of working hours and work pressures.[13] In short, domestic responsibilities, particularly the work of caring, which has traditionally been left to the 'family', or private sphere, would have to be more evenly distributed through society as a whole. This suggests that some degree of regulation (of employment and working conditions) is necessary if adaptations are to be made to the major shift that has taken place in labour markets over the last fifty years – the increasing employment of women – without increasing gender and class inequalities (Crompton, 2006).

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[1] Although overt discrimination by sex in employment has become less important, one strand within the sociology of organizations has focused on the importance of gendered identity construction and its impact on women's organizational opportunities (eg McDowell 1997, Adkins 2002). Whilst we would not wish to argue that specific cultural inputs relating to particular sexualities do not have an impact, we would nevertheless wish to argue that the generalized cultural expectation that women will assume the major responsibility for caring and domestic work – what Williams (2000) has described as the 'ideology of domesticity' – assumes a greater importance.

[2] Thanks to the BMA for allowing this access, as well as their assistance in locating interviewees.

[3] Thanks to the ICAEW for allowing this access, as well as their assistance in locating interviewees. For a more detailed analysis of this survey, and of the accountancy profession, see Lyonette and Crompton 2007.

[4] The research reported in this paper, which included funding for the interviews, was carried out as part of an ESRC GeNet project (see www.genet.ac.uk), 'Class, Gender, Employment and Family'.

[5] Hospital medicine (which means working towards qualification in a hospital specialty, see Figure 1) and General Practice are the two major career paths taken by those qualifying in medicine in Britain. Other career options are available, such as research, or academic medicine, but proportionately, the numbers are small. However, the possibility of these alternative choices meant their exclusion form this analysis and thus a reduced sample size.

[6] See Hersch and Stratton 2000 for a discussion of the male marriage wage premium.

[7] We are conscious of the fact that the employment sector classification available to us in the ICAEW survey was a very broad one. A more disaggregated classification might well generate evidence of segregation.

[8] M12 female consultant: *how many hours a week do you normally work?* Well I measured, it's varied over the years and the last year when I measured it, it was something like sixty-six hours a week and at, at, but as a consultant it's mostly been between fifty-eight and sixty-eight, but that was when I was Clinical Director and it's gone down now, but I'm just in the middle of an exercise so I don't actually know at the moment what it is, but I'm, but it's not the forty-four I'm paid for, no.

[9] The success of recent pay negotiations has led to the BMA being described as 'the NUM (National Union of Mineworkers) in white coats'.

[10] It should also be noted that even though the British government has negotiated a partial opt-out from the European Working Time Directive, governments have always been under pressure to comply with official legislation as far as their own employees are concerned. It may be suggested that this pressure was important in reducing the hours of junior hospital doctors. In contrast, in the private sector, employees are routinely expected to agree to their individual exemption from the EWTD.

[11] One should be careful not to over-generalise here. Discretionary payments ('merit awards') are available to hospital consultants, and these awards are found more frequently amongst the higher status specialties such as surgery,

[12] Some interviewees did report that employing organisations were becoming increasingly conscious of work-life issues.

[13] In Britain, these pressures are particularly intense for professional and managerial employees. See Crompton and Lyonette 2006a.