Jane Coleborn is Chief Pharmacist at the Great Western Hospitals NHS Foundation Trust in Swindon. This year she was awarded an MSc in Leadership and Management (Health and Social Care) by the Faculty of Business and Law at the University of the West of England. As part of her postgraduate study she completed a dissertation exploring the representation of women in the role of chief pharmacists, prompted by recent media coverage on the under representation of women in senior management positions in the private sector. Here Jane summarises her research.

Introduction

The increase in women in paid employment and rise in the number of women entering higher education, has resulted in an increase in women in professional roles, with a proportion now occupying positions of power and responsibility (McKinsey, 2012). However, the numbers who have reached these senior positions does not yet reflect the influx into the workforce: a large section of women remain concentrated in lower grades (Lane, 1998; Acker, 1990).

This phenomenon appears to be reflected in the proportion of female chief pharmacists in acute trusts in England. Pharmacy is a postgraduate profession that is female-dominated, particularly hospital pharmacy, with three quarters (74 per cent) of the workforce female. However, this has yet to be translated into a female-led profession with 13 out of a possible 17 (76 per cent) chief pharmacist posts in the south west of England being occupied by males.

The evidence has shown an under-representation of female chief pharmacists in the acute health care sector compared to the staff they manage: chief pharmacists are overwhelmingly male but they manage a predominantly female workforce. Women are also more likely to work part-time in both pharmacist and chief pharmacist posts than their male counterparts, but part-time working is more likely in lower pharmacist grades, where women predominate.
Another theory supported by the research is that family life is more disruptive to women’s careers than men’s careers (Singh, 2008). The majority (70%) of female chief pharmacists have had a career break and for all but one this was maternity leave. This is compared to ten per cent of males who all stated reasons other than child-related. Also a small majority (53%) of female chief pharmacists have worked part-time at some time in their career compared to men (5%). Again the reasons given for females working part-time, in all but one case, were due to childcare responsibilities.
The results indicate that female chief pharmacists are more aware of the obstacles to career progression than males supporting research by Sealy and...
Singh (2009). A greater percentage of females answered the question “what had hindered their career progression” and only women raised the issues of childcare and part-time working as being barriers. Those women who do become chief pharmacists appear to be more career-orientated; tending towards minimum maternity leave, choosing to return to full-time work rather than taking the traditional step of returning to part-time work, or a significant minority choosing not to have children at all. This is countered by the finding that shows male chief pharmacists to be more ambitious and career focused than their female counterparts. Pharmacy in acute trusts has a hierarchical structure and senior positions generally only become vacant when the current incumbent retires. With the average age of male chief pharmacist’s being higher than that for females, it would seem to follow that there is likely to be a shift in the male/female ratio of chief pharmacist in the future: as the male chief pharmacists retire they will be potentially replaced from the increasing pool of female pharmacists now populating the pipeline. This phenomenon can already be observed in the south west. At the start of this study, as previously stated, there were four female chief pharmacists out of a possible 17 posts. At present this has increased to 5.5 full-time posts occupied by women, a shift of nine per cent. A significant point of interest is the apparent reduction in time for women from qualifying to their first chief pharmacist appointment, in spite of the majority having had an on average an 18 month career break and having worked part-time.

Further investigation is required to gain a greater understanding of the paradox of a disproportionately female profession, dominated by a male hierarchy. This research has been limited to the experiences and opinions of chief pharmacists and this needs to be expanded to all pharmacists in the acute sector. In addition work also needs to be undertaken to understand the perception that part-time working and job sharing are not realistic for people in senior roles in the health sector and, finally, a piece of work to monitor the recruitment process by gender - are appointments proportionate to applications? Practical considerations that can be put into place now are the promotion of the role of female chief pharmacists as mentors and ensuring training is availability to all staff regardless of whether they work full-time or part-time.
Conclusion

In conclusion the research showed that there are potential barriers to the progression of women to becoming chief pharmacists, and this is supported by the findings. The pharmacy profession itself does not appear to be gender-biased but there are potential barriers to career progression for women which are common across many professions; these barriers are covert rather than overt, but point to the gendered nature of part-time working and the structuring of work around full-time hours.

It would be interesting to repeat this research in the near future and establish whether the apparent trend identified in the research, that there is a cohort of young females progressing through the pipeline, is realised in the appointment of more female chief pharmacists, reflecting the increasing numbers of females graduating with pharmacy degrees.

References


