The Representation of Women in the Role of Chief Pharmacist in Acute Trusts in England

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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.

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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.




Research undertaken by, for example, Marshall (1995), Tomlinson and Durbin (2010) and organisations such as McKinsey & Company and Cranfield University have highlighted the potential barriers to career advancement. These include an absence of flexible working, the need for those in senior positions to work more than contracted hours and consequent difficulties in balancing work and family life, the requirement to be geographically mobility, the lack of role models, mentoring, professional networks and training.

This research aimed to explore the barriers to career advancement for women in pharmacy through a survey, conducted by a postal questionnaire. This was chosen above alternative methods such as interviews and focus groups, not only because of the demands on the time of the interviewer and the interviewees, but also and perhaps more importantly, due to the opportunity it gave the researcher (as she is a chief pharmacist herself) to capture the thoughts and experiences of the whole population of chief pharmacists in England. Of the 164 questionnaires sent out, a 60 per cent return rate was achieved. As well as replicating the ratio of males to females in the profession as a whole (65:35), this is representative of the gender balance amongst chief pharmacists in acute trusts in England.

The findings of the dissertation support some theories identified in the literature but not all. Flexible working is one, with a prevalence of part-time working amongst female pharmacy staff, 34 per cent compared to eight per cent of male staff. However, the majority of those in part-time posts are those in lower grades. Responses to the questionnaire showed that of the 98 respondents only seven (7%) chief pharmacists currently work part-time, five women and two men. In Pharmacy, as with other professions, the more senior the position the more managerial responsibility this will attract with a comparative decrease in the amount of direct professional involvement. Managerial positions tend to adopt the male model of working (Lewis, 2001) – long unpredictable hours, career mobility and networking out of hours. Another theory supported by the research is that family life is more disruptive to women's careers than men's (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.

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Lack of geographical mobility in the job market is also seen as a barrier to women's career advancement. Women are less mobile than men because of family pressures and the fact they are often not the primary wage earner (Tracey and Nicholl, 2007). The survey results show that more male chief pharmacists have relocated due to being appointed to a new post than female chief pharmacists, while female chief pharmacists have moved twice as often as their male counterparts because their partner has relocated.

The research findings do not support theories relating to the availability of role models, mentorship, and access to professional networks. Results indicate that the proportion of chief pharmacists that had a role model was similar for both sexes, past and present. With 17 per cent of males and 24 per cent of females having a role model now and 61 per cent of male and 55 per cent of females having one in the past. There is a similar picture for access to mentors amongst chief pharmacists, though potentially females would benefit more from mentoring than their male counterparts; the Davies report (2011) considered mentors to be one of the most important factors in a woman's career success and the absence of this relationship as a barrier to advancement. The vast majority of chief pharmacists of both sexes have access to a professional network. When asked whether they had found it useful to career advancement 62 per cent of the men thought that it had, compared to 53 per cent of women. Tracey and Nicholls (2007) have shown that women continue to engage in personal development throughout their careers, more so than men. However the findings in the dissertation do not support this theory showing that 95 per cent of male chief pharmacists and 88 per cent of females have gained additional qualifications since qualifying. Although the responses were analysed to identify trends and themes it appeared that there was not a huge difference in experiences in the career pathways of male and female chief pharmacists.

The key issue identified in the findings is that a much smaller proportion of female pharmacists become chief pharmacists. However, the findings also indicate that there is a younger cohort of women progressing through the pipeline. Female chief pharmacists, who are on average younger than their male counterparts, are attaining the post of chief pharmacist earlier in their career than in the past, unlike male chief pharmacists who demonstrate little change in this aspect. The results indicate that female chief pharmacists are more aware of the obstacles to career progression than males supporting research by Sealy and

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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.

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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.

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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.

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