

**BMA commentary on  
Mend the Gap:  
The Independent Review  
into Gender Pay Gaps in  
Medicine in England**





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## Summary

### The gender pay gap in medicine

There is a gender pay gap of **18.9% for hospital doctors, 15.3% for GPs and 11.9% for clinical academics** (once adjusted for differences in working hours).

The total non-adjusted gender pay gap is **24.4% for hospital doctors, 33.5% for GPs and 21.4% for clinical academics**. These figures are higher than those above because a significant amount of the gender pay gap can be explained through women, on average, working fewer contracted hours.

### *The gender pay gap and equal pay*

The gender pay gap compares the average pay of all women and men working in a sector or a profession. The gender pay gap is calculated using full-time equivalent pay, or hourly pay to give a better 'like for like' comparison. A 24.4% gender pay gap for hospital doctors means the average pay of all female hospital doctors is 24.4% lower than that of all male hospital doctors.

The gender pay gap is different from equal pay. Equal pay for equal work is a legal right set out in the Equality Act 2010. It means a woman doing the same work as a man, or work that is different but of equal value (eg in terms of effort, skills, knowledge, responsibility), is entitled to the same pay.

Instances of unequal pay may contribute to an overall gender pay gap. However, differences in workforce composition and the kinds of jobs men and women do are more likely to be significant drivers of the gender pay gap. These differences may result from women experiencing discrimination or greater hurdles in accessing particular jobs or progressing in them.

## Causes of the gender pay gap in medicine

There is no gender pay gap at the start of medical careers. It emerges in the later stages of training, between the ages of 30 and 40, when many women have children. Women's earnings only start to catch up with men's after the age of 60.

The gender pay gap in medicine is significant. According to the review, this is mostly because of the under-representation of women in the highest paid positions, grades and specialties. However, even after adjusting for age, seniority and a range of other factors (ie doing a more 'like for like' comparison) a gender pay gap remains.

The review identifies additional causes that are 'multiple and complex'. Among them are:

- the unequal impact of caring responsibilities on careers. Women doctors are more likely to take time out or have periods of working or training LTFT (less than full time) to care for others. This has a disproportionate impact on their pay even after accounting for the reduced hours worked and periods of leave.
- medical careers have failed to evolve with changing demographics and working patterns, resulting in a lower average salary for the female workforce. The structure of medical

careers was designed originally for a predominantly male workforce, with the expectation of full-time work for a long career and an ability to take on extra commitments.

- women are segregated into lower paid career paths – particular roles and specialties. This is due to the difficulties working LTFT, or the structure of careers in some specialties. This results in pay penalties, especially relating to non-basic pay additions, such as CEAs.

### Reasons for the review

The gender pay gap review was announced in response to the BMA raising concerns about the gender pay gap in the 2016 junior doctor contract negotiations.

In 2018 the Department of Health and Social Care commissioned the independent review into the Gender Pay Gap in Medicine in England to establish a strong evidence base and make recommendations on the changes needed to achieve equality in the profession. The review was chaired by Professor Dame Jane Dacre and the research was conducted by Professor Carol Woodhams. We were represented on the steering group for the review along with other stakeholders, such as the Medical Women's Federation, the GMC, NHS Employers and HEE. The scope of the review was England only, however, our representatives from the devolved nations joined the steering group as observers so that lessons could be learned and insights shared across the nations.

The recommendations in the review were not formally agreed by the steering group that we were a part of. However, there was engagement and discussion around the findings and themes for recommended action.

### Review recommendations

The review makes a total of 47 recommendations but has focused on six main recommendations. These are:

#### *Review pay-setting arrangements*

- Among hospital doctors, this means using fewer scale points and greater use of job evaluation. The aim is to ensure that gaps related to grade are justified.
- Encourage more structure and greater transparency in GP pay setting. Decentralised or local practices in pay setting can increase gender pay gaps.

#### *Give greater attention to the distribution of additional work and extra payments*

- Increase transparency around additional allowances and individually negotiated pay (for example, for locums or waiting list initiatives). An expanded workforce would reduce dependence on these gender-segregated pay elements.
- Monitor the gender split of applications for CEAs; change the criteria to recognise excellent work in a broader range of specialties; and encourage more applications from women.

#### *Promote flexible working for both men and women*

- Advertise all jobs as available for LTFT.
- Reconsider the structure of LTFT training, so that it focuses on competency not time served, reducing long-term career penalties.

## Learning from the review

The Independent Review into the Gender Pay Gap in Medicine, provides detailed analysis of the pay gaps, looking at different grades and elements of pay, and uses decomposition analysis to identify the main contributing factors.

The review involved: an analysis of a large amount of data; 30 in-depth interviews with men and women doctors; and, a GPGiM (Gender Pay Gap in Medicine survey) which was sent to a representative sample of doctors on the GMC register. The survey and interviews give further insight into the main drivers of the gender pay gap and gender equality in the medical profession. Selected quotes from the interviews that have been used in the review are used in the briefing below.

The review is extensive and has chapters that focus specifically on the issues of: gender pay gaps in HCHS (hospitals and community doctors); GPs and clinical academics; the causes of pay gaps from the perspective of; the individual, including family and career; as well as the workplace, structural and cultural elements.

### COVID

*The Independent Review into the Gender Pay Gap in Medicine was written before the Covid-19 crisis. It therefore has been unable to build on the positive learning and innovation that has happened during the pandemic and build those into the recommendations. Changes such as the shift to normalising flexible and remote working are necessary steps to closing the gender pay gap and we want to ensure these positive changes continue.*

*It has also been unable to reflect on the inequalities that have been highlighted and exacerbated during the pandemic. It is important that we recognise the [impact that Covid-19 will have on the gender pay gap](#) now and in the future. Being cognisant of the negative impact on women doctors and ensure these are not built into the 'new normal' ways of working.*

### Our position

We welcome many of the recommendations, however, there are three significant issues to raise at the time of publication.

- Firstly, as noted in the review, some of these recommendations clearly require contractual change and potentially changes to pay structures.
- Secondly, due to the time that has passed since the research was initiated the data and recommendations may be less relevant.
- Thirdly, there have been significant changes to the health system due to Covid-19, and we must view all the findings with consideration of the current environment.

There are some areas where the recommendations lack detail, or we believe the review could have gone further (eg in efforts to change culture), and some areas that were unfortunately overlooked (eg the unfairness of LTFT pension contributions). We highlight these issues below.

In response to the findings we are calling for:

- more support for doctors when they have children or other caring responsibilities to minimise the career costs of caring. In mixed-sex couples men should be encouraged to take time off work and play more of a role in caring. This will challenge stereotypes around gender, work and care and minimise the disproportionate impact of caring responsibilities on women.

- enhanced pay for shared parental leave to be extended to all doctors (building on the GP contractual changes referred to below that provide for more generous SPL)
- gender pay gap monitoring and reporting to be standardised.
  
- more work to be done to understand the differences in the gender pay gap at the intersection of different protected characteristics eg race and disability.
  
- poor behaviour, stereotypical attitudes and bullying cultures to be tackled to create an inclusive environment for all doctors.
  
- structural change so that issues such as treating LTFT doctors differently without justification stop.

We will continue to carefully consider the review findings and push for the necessary action to narrow the gender pay gap in the profession.

### How to reduce the gender pay gap in medicine

The review makes 47 recommendations grouped under seven themes.

**Theme 1:** Address structural barriers to the career and pay progression of women

**Theme 2:** Make senior jobs more accessible to more women

**Theme 3:** Introduce increased transparency on gender pay gaps

**Theme 4:** Mandate changes to policy on gender pay gaps

**Theme 5:** Promote behaviour and cultural change

**Theme 6:** Review clinical excellence and performance payments and change accordingly

**Theme 7:** Implement a programme for continued and robust analysis of gender pay gaps

Below we have explored in greater detail some of the issues that were highlighted in the review that we believe are a priority in the current environment.

### Reducing penalties for working and training LTFT

The GPGiM survey confirms that women are more likely to have a period of working or training LTFT, often to help accommodate childcare. LTFT working increases in the later stages of training and significant gender differences emerge – among speciality registrar/ST3s, 25.6% of women work or have worked LTFT compared to 9.1% of men. Among consultants 41.5% of women work or have worked LTFT compared to 15.4% of men, and among Associate Specialists, it is 59.4% of women and 8.3% of men.

Being LTFT leads to a pro-rata reduction in pay, but there are also disproportionate costs incurred as things like professional fees are not pro-rated to reflect LTFT trainees' reduced hours and earnings. We have secured an allowance of £1,000 a year for LTFT trainees to help cover these costs. We have also successfully lobbied for steps to make other payments fairer, such as changes to the GMC's income discount scheme to accommodate women who take maternity leave.

The review has also found LTFT doctors face long-term impacts in terms of slower career progression and more limited development and earning opportunities and LTFT doctors also face negative stigma. For example, LTFT trainees were made to feel 'guilty and weak' or were criticised for showing a 'lack of commitment'. A male doctor who wanted to train LTFT to take on more caring responsibilities said:

*You're chatting to people and they were like, 'Well, you might be able to do it but it's frowned upon and... they expect you to just man-up and get on with it and get through to the end of it.'*  
M, 34

- We welcome recommendations in the review around promoting flexible working, advertising flexible work and job-share opportunities when recruiting, removing stigma and encouraging more men to take LTFT options. We were pleased to see this commitment in the NHS People Plan 2020/21.
- The review calls for a shortening of the overall length of LTFT training through a focus on an acquisition of competence rather than time served. However, we need to ensure that the ability to shortening the length of training does not pressurise LTFT trainees to complete their training before they feel ready.

In addition, we believe:

- there should be a review of pension contributions to ensure fairness and affordability for LTFT doctors. At present, contributions are based on full-time equivalent earnings rather than actual earnings for LTFT doctors so pension contributions account for a larger proportion of their reduced earnings.
- that flexible working champions, developed by the BMA and NHS Employers, should be extended to other grades to provide support to those working LTFT. The champions promote, support and, where necessary, advocate on behalf of LTFT trainees and aim to help change NHS culture.
- the option of training LTFT for any reason (rather than having to fit into specific categories such as caring, parental or disability reasons) should apply to all specialties in order to facilitate and normalise LTFT working among men and women. We have welcomed the pilot of this policy in emergency medicine and the recent extension of it to paediatrics and obstetrics and gynaecology.
- HEE and NHS Employers should look at how they can protect placement allocations for trainees who go on maternity/parental leave or who apply to train LTFT, with a view to ending the situation where original allocations won in open competition are lost if a trainee takes time off or applies to go LTFT.

Whilst the expansion of flexible opportunities is welcome and has the potential to improve the working lives for all doctors. It must be reconciled by addressing the pressing need to increase staffing levels across the NHS and planning to ensure that this does not leave rota gaps and an unfair impact on other doctors.

### **Men's careers – privilege and geographic mobility**

*What's ended up happening is that they've moved to the location where the male has got the training post and the female has ended up in a GP programme because that's reliable and easier to get into. F, 28*

According to the GPGiM survey, 29% of women doctors said their partner's career was a barrier to their own career progression, in comparison to just 15% of men. This is more likely to be the case when both are NHS doctors. The wide geographical spread and remoteness of some training placements were cited as having negative impacts on career paths. It was also the reason why couples of two NHS doctors often choose to prioritise one partner's career, with the other, usually the woman, taking a step back or adapting their career around their partner's and family's needs.

The review pointed out that the new training schemes introduced in the Modernising Medical Careers (MMC) policy in 2005 had created new career barriers for trainees, particularly women. For example, it is challenging for a doctor with children to decide which school to send their child to when the geographical spread of their training programme can cover multiple counties and they have limited control of where they are posted.

- We welcome the review's recommendation that there needs to be increased opportunities for trainees and their partners to move between geographical regions and better relocation policies and funding.

Since the review was written, the BMA has negotiated the new national relocation and excess

travel framework which is consistent with the above recommendation. For example, trainees moving between training regions, due to IDT, will be able to claim eligible expenses under this policy, whereas previously all costs would have been borne by the trainee. The new framework will also reduce immediate additional pay penalties for doctors who's training exceeds eight years, as they will now be able to submit claims for excess mileage/relocation expenses which exceed their maximum allowance.

### Improving support around pregnancy and maternity leave

There is no gender pay gap at the start of doctors' careers. It emerges at the specialty training stage or when doctors are around the age of 30, a grade and age when many start to have children. The review has found that women doctors face disproportionate career and financial costs from having children compared to their male counterparts. The costs are long-term as women fail to catch up in the later stages of their careers because the structure and culture of medicine places career and pay penalties for doctors who do not work full-time or do not finish training in the expected amount of time.

*It seems like, every time somebody has a baby in the NHS, everyone's completely surprised, as if it's never happened before... Well over 50% of the medical workforce is female, and yet we still have not made it possible for women to combine motherhood and being doctors F, 45*

Both men and women interviewed agreed that there was a 'huge penalty for childbearing' in medicine, with pregnant women being offered worse career opportunities or concealing their pregnancy when going for interviews out of fear they would not get the job. Women in training stated that they were required to 'push through' even when they were heavily pregnant in order to not fall behind, this has health implications on the mother and unborn child, particularly when being pushed towards unsocial working hours. Women returning from maternity leave felt a lack of support to help them settle back into work.

The review recommends standardised maternity pay policies in general practice. The salaried GP model contract, which salaried GPs working in GMS and PMS practices receive, includes provisions around maternity pay policy. In the 2020/21 GP contract negotiations, we secured a commitment to agree arrangements that will allow practices to make a more generous offer of enhanced shared parental leave.

*I'd lost my nerve, basically, because I'd been out for so long. It felt, the longer I left it, the bigger thing it was to come back in. F, 39*

Pregnant doctors must be properly supported at work, with adjustments made to ensure the health and wellbeing of the mother and unborn child are protected, we believe:

- lessons learned from Health Education England's SupportTT (supported Return to Training) programme, local good practice and initiatives like the AoMRC's return to practice checklist, should inform improvements to return to practice support for all doctors, with greater national co-ordination and signposting by royal colleges and NHS Employers.
- all doctors should have access to a mentor and/or a peer support network to help build confidence during the transition back to work. Further funding should be given to ensure sufficient levels of educational supervision. In general practice a mentoring scheme has now been introduced following on from an agreement in the latest GP negotiations.
- GPs should have access to occupational health services to ensure that pregnant women can get the adjustments that they need. Ensuring all GPs have the option of getting an occupational health assessment will also improve support for doctors with disabilities or long-term conditions and doctors going through the menopause.

## Improving access to affordable childcare

In the GPGiM survey, 35% of women doctors and 31% of male doctors said the lack of affordable childcare was a barrier to career progression. In 2019, parents in the UK faced the highest net childcare costs across the OECD, with typical households spending around 28% of their income on childcare.<sup>1</sup> Many doctors face additional costs as a result of the long hours and shift working. Short notice rota changes also make childcare more expensive and difficult to arrange. The inflexible allocation of training places makes it difficult for trainees to move between regions where more extended family support may be available. The impact of Covid-19 has led to additional pressures on childcare resources. Many doctors struggle to manage these costs on their current salaries.

The need to improve access to childcare to better meet the needs of doctors formed a key part of recommendations from Baroness Deech's report on women in medicine over a decade ago<sup>1</sup>. As the report said: 'Looking after children is an important phase in life, but its crucial decisions made at this time do not deleteriously affect future careers.' The report stated that childcare was the most widespread area of concern for women in medicine. However, in some ways we have gone backwards. The cost of childcare has significantly increased over the last decade, and we have seen the closure of hospital nurseries – there are now just 62 NHS hospitals with nurseries attached.

- We welcome the review recommendation to increase provision of NHS nurseries and other support for childcare, including access for doctors working in primary care to accommodate out-of-hours and shift working.

We are aware that the cost of childcare has led to GPs opting not to return to work. We have therefore successfully negotiated that from April 2020, GPs on the Induction and Refresher Scheme with children aged under 11 will be able to claim up to £2,000 towards the cost of childcare for each child whilst on the scheme. In addition, we believe:

- there should be an immediate commitment that hospital nurseries under threat of closure will remain open. The collapse of the childcare and early-years sector as a result of the pandemic has made this crucial.
- the difficulty in arranging childcare must be recognised and all doctors must have sufficient notice of rotas. We secured [fixed-day flexible working for LTFT trainees in the junior doctor contract review in 2019](#) so that LTFT employees can ensure they are working the same days each week, making it easier and more affordable to arrange childcare. Now the contract is being implemented we need to ensure that this is being actioned by employers.
- the childcare and early-years sector needs urgent emergency funding from the Government following the impact the Covid-19 crisis (including local and national lockdowns) has had on the sector. It is estimated in England that organisations have lost up to £228million during this period. Damage to the childcare and early-years sector will disproportionately impact working women.

Difficulties accessing childcare were exacerbated when the lockdown measures were introduced during the Covid-19 pandemic. We highlighted the challenges doctors were facing and additional support they need in this [report](#).

## Shared parental leave

The GPGiM survey highlights that female doctors were more likely to allocate time caring for children to themselves, while male doctors were more likely to allocate childcare to their partners. The review also describes how attitudes to gender and caring roles are deeply embedded in the profession.

*My partner had picked the baby up, and the registrar went, 'Where's [your partner] gone?' and I said 'Oh, he's gone to get the baby' and he said, 'Well, isn't that your job, shouldn't you be doing that?' F,32*

Stronger parental leave rights enable fathers to play an active role in early-years care and can be more supportive in women's careers. The Nordic countries offer generous and flexible parental leave rights to mothers and fathers, these countries are also leaders in gender equality.

We successfully secured enhanced shared parental leave for junior doctors in England from April 2019 and have been campaigning for it to be extended to other doctors since. A commitment to introduce it as soon as possible for salaried GPs has been included in the new GP contract.

- We welcome the review's recommendation that enhanced pay for shared parental leave should be extended to all doctors.

This should be implemented as soon as possible. It needs to be extended to senior hospital doctors – consultants and SAS grades – as soon as possible and this equality right should not be used as a bargaining chip in contract negotiations.

We also recognise the need for further changes to our parental leave system. In response to the recent Government consultation on reforming statutory leave rights, we have called for:

- fathers and partners to have better well-compensated, stand-alone rights to parental leave, rather than being dependent on the mother cutting short her maternity entitlement and transferring leave. This is based on evidence from other countries where fathers' leave-taking significantly increased when they introduced 'use it or lose it' parental leave for fathers and partners rather than shared entitlements.

We are collaborating with the Medical Women's Federation to continuously raise the importance of men taking on a greater role in a child's early years.

It is vital to acknowledge that women's caring responsibilities are not limited to childcare. Across the UK women are more likely to hold other caring responsibilities. According to Carers UK, women make up 58% of unpaid carers and women aged 45-54 are more than twice as likely as other carers to have reduced working hours as result of caring responsibilities.

We welcome the commitment in the NHS People Plan which calls on employers to roll out the [new working carers passport](#). This includes establishing and protecting flexible working patterns.

## Making senior jobs more accessible to more women

A significant portion of the gender pay gap is down to women being under-represented at senior levels and in the highest paid specialities. More must be done to remove constraints on career choices and encourage all doctors to contribute and achieve their full potential.

We believe that when it comes to implementing action following this review, there must also be a strong focus on the retention of doctors in the system. The review surveyed doctors on their intention to leave medicine before the typical retirement age and found that this was more likely to be the case among doctors who work LTFT. This suggests that in order to improve retention more must be done to build flexible career pathways and inclusive working environments across the medical profession and into management and leadership. We must also ensure that the NHS is properly staffed to so we do not continue to lose doctors because of burn-out and exhaustion.

As Baroness Deech said, after chairing a similar review over a decade ago: 'We should make our goal a profession where every woman and every man goes as far as they wish and as far as their talents permit. **The final judgement... will lie in retention of doctors within the system**, both men and women.'

We support the NHS [New to partnership Payment scheme](#) which was introduced as part of latest national GP contract. We hope it will encourage a more balanced senior workforce. Currently women are underrepresented in partnership roles. 44% of fully qualified GPs are men, but 55% of GP partners are men. The scheme is:

- designed to increase the number of partners in general practice and stabilise the partnership model.
- participants must commit to a minimum of five years working as a partner.
- successful applicants receive funding to support their start as a partner.

We are supportive of the recommendation to agree measures to address factors that are deterring women from becoming a GP partners.

### Improving retention and flexible career pathways

Our junior doctors committee welcomed the focus on flexibility in the third report of HEE's [Enhancing Junior Doctors Working Lives](#) working group which was created following the 2016 junior doctor contract dispute to help retain trainees. New initiatives announced include the Out of Programme Pause initiative and the RCP Flexible Portfolio pilot.

As the review highlights some women have found speciality training programmes inflexible and incompatible with caring responsibilities and have become SAS (speciality doctors and associate specialists) doctors to gain greater flexibility, plannability and geographic security. Becoming a SAS doctor can be a positive career choice, particularly in terms of offering better work-life balance. However, SAS doctors face stigma, undermining and unpleasant treatment – as one SAS doctor told the review they felt 'underappreciated, belittled, demeaned and not listened to' F, 45 – and it limits long-term career development and earning potential.

The closure of the associate specialist grade in 2008 had a negative impact on SAS doctors as it removed career and pay progression and led to an increase in locally agreed contracts without pay transparency. Since its closure, we have been calling for the reintroduction of an associate specialist grade to improve career and pay progression for SAS doctors and improve morale for this valued part of the NHS workforce.

The CESR route onto the specialist register can also be expensive and difficult to manage with caring responsibilities and needs to become less burdensome and more affordable. We are aware that doctors who take more than one or two periods of maternity leave find the five-year limitation on evidence incredibly difficult.

The review calls for a deregulation of the pathway to CCT and removal of the career and pay disadvantages for doctors following alternative career routes. While we are wary of any deregulation of the process, the principle of making the CESR process more streamlined and more affordable is something we support.

*The experiences [of colleagues doing CESR] were really...mixed and not very encouraging. It's a very laborious process. It feels like the amount of evidence you have to acquire is way and above what anyone in the standard training route would have to collect. It's phenomenally expensive and time-consuming, and then, even once it's achieved, you're still viewed as less... your worth still seems to be less than someone who's gone through the standard route. F, 54*

We believe:

- the CESR training route should be made a more accessible and affordable pathway for doctors with caring responsibilities or doctors who take parental leave. The GMC has [taken some steps](#) towards making the CESR route more manageable for doctors and there has been an increase in applications. This includes the move towards evidence being submitted electronically and improving the verification process. We will continue to collaborate with the GMC to improve CESR.
- SAS doctors applying for CESR should be given support from their employers, as set out in Health Education England's [Maximising the Potential](#) report.
- Trusts should accelerate the implementation of the [SAS Charter](#) which sets out what SAS doctors are entitled to and how their employer should be supporting them. The BMA and NHS Employers have developed a [range of resources](#) to support employers, SAS doctors and LNCs (local negotiating committees) enforce the Charter.

### Encouraging more women into male-dominated specialties

The review highlights that there is under-representation of women across the highest-paid specialties, and the women who are in them tend to be at the lower end of the pay scale. For example, 31% of doctors specialising in surgery are women and the specialty has a gender pay gap of 21.7%.

The review highlights cultural barriers to women entering some specialties, particularly male-dominated ones, with perceptions that they would have to adapt their behaviour or expect a less supportive environment.

*It just was very macho and... I thought you would have to be pretty determined to want to do that, to go through... I was full of admiration for the women who had achieved it, but there weren't many of them around, and they were all considered to be not very female. F, 54 (On working in surgery)*

Women doctors were also significantly more likely to cite work-life balance factors when selecting the area of medicine to specialise in. They were four times more likely than men to say work-life balance was an important factor. Some women interview participants also made comments that indicated their choice of speciality was constrained by working hours requirements and they would have made different choices if other specialties had better work-life balance.

*Your career options that used to be wide-open, the possibilities that used to be open are closed-down, because you always had to pay for childcare in order to do these things, as a part-time trainee. F, 32*

- the review recommends improved careers guidance in medical schools and early careers that is equality-proofed and doesn't perpetuate stereotypes.
- the review recommends HEE, royal colleges and specialist societies, among others, set targets to address the balance of the numbers of men and women across the specialties and at more senior levels in each specialty, and monitor results and progress.

In addition, we believe:

- the numbers working LTFT in each specialty should also be published and action plans to improve gender balance should underpin the targets, reviewing and learning from current initiatives like [Women in Surgery](#).
- action should also be taken to consider intersectional barriers for some women, for example, the barriers to female Muslim women entering surgical specialties because of the failure to reasonably accommodate religious [dress requirements](#).

In addition to encouraging more women into higher-paid specialties and roles that are currently male-dominated, further analysis should be done on whether medical jobs, tasks

or roles that are mainly done by women are valued equally in the profession to those mainly done by men.

### Accessing senior positions

The review states that senior posts need to be more accessible to women. The review demonstrates that these roles are tailored for full-time doctors, and examples are given of women not being made aware when senior roles they were eligible for became available.

Unfortunately, the review does not explore the impact that menopause is having on the number of women doctors in senior positions. Our [menopause survey](#) found that an absence of sufficient support for doctors going through the menopause was leading to them stepping down from senior positions or even leaving medicine early. A change in culture towards the menopause and offering adjustments to women to help them manage their symptoms should be a priority of employers.

We support the review's recommendations that:

- employers, when advertising senior roles, should make clear that they are available on a reduced hours or flexible basis, for example LTFT or through job-shares. If an employer does not believe that a role cannot accommodate flexible working they must provide strong justifiable and documented reasons as to why not. They should publish their flexible working and job-share policies on their website in a way that is accessible to all potential employees.
- talent management and training programmes should be used to develop staff and increase the appointment of a more balanced senior workforce. We support the commitment in the NHS People Plan to give greater prioritisation and consistency of diversity in talent is being considered for senior positions.

In addition, we believe:

- senior women and doctors working flexibly at senior levels in the profession should be made more visible so they can act as role models to others. We have developed a [Network of Elected Women \(NEW\)](#) representatives who will champion and strengthen female leadership.
- HR policies are regularly updated to include the agreed working and training entitlements for all doctors. HR staff should be fully trained in the varying forms a doctor's career can take and informed on the contractual entitlements agreed and best practice approaches. This should avoid doctors facing the additional pressure of arguing for rights with their employer that have already been agreed.
- employers should take a pro-active approach to normalising the topic of menopause and spread awareness of the impact symptoms can have on work. Adjustments should be made to the workplace and increased access to flexible working should be available to make symptoms more manageable and prevent the menopause having any detrimental effects on career progression.

### GP partnership

General practice is a common career choice for those who are seeking a better work-life balance. According to the review, both men and women working in general practice are more likely than hospital doctors to say they work LTFT and have child-care responsibilities. However, there are significant gender inequalities within general practice. Women are under-represented at senior levels – 73% of salaried GPs are women but only 43% of GP partners are. There is also a gender pay gap of 22.3% for salaried GPs, which is three times the size of the gender pay gap for GP partners.

Our GP sessional committee has undertaken a survey of salaried GPs to look into their earnings. We are currently using this data to establish next steps to address local discrepancies in pay.

- We welcome the review recommendation that measures are agreed to address the factors that are deterring women from becoming GP partners. Within the new GP

contract, there is a commitment to review and make changes to tackle the gender pay gap in general practice and this review will no doubt be considered within that.

We support the NHS [New to partnership Payment scheme](#) which was introduced as part of latest national GP contract. We hope it will encourage a more balanced senior workforce. Currently women are underrepresented in partnership roles. 44% of fully qualified GPs are men, but 55% of GP partners are men. The scheme is:

- designed to increase the number of partners in general practice and stabilise the partnership model.
- participants must commit to a minimum of five years working as a partner.
- successful applicants receive funding to support their start as a partner.

We will continue to emphasise the benefits of partnership and the flexibility of partnership working that allows more opportunity for varying sessional work at different stages of a career.

Closing the pay gap for GPs is dependent on practices receiving the funding and staff they need to implement the changes needed to have greater equality and the profession whilst being able to run their practices safely and effectively.

### Clinical academics

The review highlights that in clinical academia women are also overrepresented in the lowest-paid roles. They are more likely to be on teaching-only contracts, making up 64% of these positions. In comparison the highest paid teaching and research roles, women hold 27% of these positions. The teaching-only roles also have the largest gender pay gap (10.7%).

The review has few specific recommendations for this area of the workforce. However, we have long been aware of the imbalance of men and women in academic medicine, particularly in the highest-paid roles. Our medical academic staff committee established the Women in Academic Medicine group which advises the wider-BMA on what action we should be taking to support women working in academic medicine. They have recently undertaken a survey on career progression which showed that the environment for medical academics needs to modernise, become more flexible and more like the NHS. Survey respondents wanted a change in the way academic performance is measured to better recognise women's contributions, more protection of career opportunities for women on maternity leave and an introduction of mentoring that is more tailored to women's needs.

- We welcome the recommendation to review pay gaps in medical schools, addressing the difficulties in accurate measurement caused by clinical academic contracts.

We believe that to improve career opportunities for women in academic medicine:

- further work should be done on understanding the root and branch causes of the gender pay gap in academic medicine and what policies need to be put in place to resolve them. Evidence is needed on why many women are opting to leave the sector.
- universities should increase opportunities for LTFT clinical academics to receive funding, this could be through an expansion of programmes such as the [Chadburn Lectureship scheme](#).
- better valuing of roles traditionally undertaken by women: teaching and pastoral support and the management of these roles. Female academics are more likely to undertake non-traditional areas of research that do not have long-standing sources of research funding or well-established career structures.

## Sexism and sexist attitudes

The review describes and provides examples of sexism and sexist behaviour within the profession. From medical school, women said they learned there were 'pretty clear lines being drawn about which jobs were appropriate for women and which weren't'. This included senior doctors openly stating a preference for male trainees because 'girls are so much trouble'. One doctor revealed male trainees appeared to be given more opportunities to perform particular operations than female trainees and in order to gain the same experience some women doctors said they felt they had to conform to a masculine culture. Double standards were also felt to apply in some situations. One participant described a colleague who 'could be hot-headed, and rude sometimes, but so could a lot of men, but it's forgiven in a man and it's not forgiven in a woman'.

There needs to be a shift in the NHS towards an open and learning culture in which sexist attitudes and behaviours are not tolerated. The BMA's [Caring Supportive Collaborative \(CSC\)](#) is a programme of initiatives that seek to change the culture and environment in the NHS to better support doctors to provide excellent care. It includes work on retention and pay (such as reducing the gender pay gap through negotiations) and working with other bodies to produce a civility toolkit to promote a positive workplace culture.

## Bullying and harassment

In the GPGiM survey 19.4% of women said they were held back in their careers by bullying, in comparison to 17.3% of men. We know from our bullying and harassment project that other doctors with other protected characteristics – BAME doctors, disabled doctors and LGBT doctors – are more likely to experience bullying and harassment too, which is likely to act as a barrier to them as well.

The review recommends enhancing and enforcing bullying and harassment procedures, adopting a zero-tolerance approach and providing multiple channels for speaking up. We believe more widespread action is needed to change culture. In addition to our work referred to above, our [bullying and harassment report](#) recommended the following steps to create a more supportive and inclusive culture:

- equipping individuals to be better able to distinguish when behaviour may be crossing a line into bullying or harassment.
- raising awareness of human factors and understanding the impact incivility has on colleagues and patient care.
- providing the tools to enable people to be active bystanders and effectively call out poor behaviour when they experience or see it.
- giving managers the time, support and training to intervene sooner and address inappropriate behaviour at an early stage before it escalates to bullying and harassment and the need for formal procedures.
- developing compassionate and inclusive leadership throughout the system.

## Intersectional discrimination

The review was unable to provide a detailed analysis of pay gaps by gender and other protected characteristics. Any commitment to create gender equality must include intersecting identities and greater research into this needed.

However, they did identify when looking at similar individual characteristics, men with the same characteristic, for example men and women from BAME backgrounds, and men and women of poor health (not the same as disability).

From their interviews, they included experiences of women who faced multiple disadvantages as a result of intersecting characteristics. For example, two out of the three Asian women mentioned negative experiences they had faced at medical school that had a lasting impact on their career trajectories.

One of the interviewees was with a trans man who transitioned during medical school explained the discrimination he faced, being told by his tutor ahead of his transition 'You can't come back unless you're absolutely obviously able to present an acceptable appearance to patients'. This discrimination would no longer be legal.

Other research has highlighted that an ethnic pay gap exists in the NHS and women from BAME backgrounds receive lower average pay than white men, men from BAME backgrounds and white women. Research on pay gaps across the economy also highlights significant pay penalties for disabled workers, with disabled women experiencing the greatest penalty.

- [Our report](#) into disability in the medical profession showed that there are similarities to the experiences of women and disabled doctors. There are similar calls in both reports for a more flexible, inclusive and compassionate system. We welcome the review recommendation of future, broader pay gap research in the NHS to provide an equivalent evidence base for other protected characteristics and do a more in-depth evaluation of intersectionality, where protected characteristics are overlapping.
- we have supported the introduction of mandatory ethnic pay gap reporting by large employers to mirror the mandatory gender pay gap reporting requirements introduced from 2018.

We also support:

- the commitments in the NHS People Plan 2020/21 to diversity and inclusion and initiatives such as the Workforce Race Equality Standard the NHS Race and Health Observatory and the Workforce Disability Equality Standard.
- widening participation initiatives which offers opportunities to people who are under-represented in higher education. Our [aspiring doctors programme](#) supports students who may face unfair barriers to entering the medical profession.
- a pay gap analysis by all possible protected characteristics.

*Covid-19 has highlighted and exacerbated inequalities in health and social care as well as wider society. The intersectional impact of Covid-19 on our doctors was highlighted in a [panel discussion](#) held at our ARM (annual representative meeting) in September 2020.*

### **Equality in medical pay and contracts**

The review findings enable us to consider in more detail where there may be factors within medical contracts that could be contributing to the gender pay gap and risking unjustifiable gender pay differences.

The gender pay gap review itself was announced in response to us raising concerns about the gender pay gap in the 2016 junior doctor contract negotiations. We have played an active role in pressing for thorough equality impact assessments, with better data and consideration of gender pay gap issues in recent contract negotiations. For example, we commissioned an [independent expert review](#) of the DHSC's Equality Impact Assessment in the recent junior doctor contract review.

The review has identified a number of issues that we will consider in more detail. Some factors identified by the review have been or are already being addressed in contract negotiations and we will continue to consider the relevant points in future negotiations as the working environment changes with the impact of Covid-19.

## Negotiating salaries

The review identifies that women are at a disadvantage when contracts and salaries are up for individual or local negotiation. As many similar studies on the gender pay gap demonstrate women are less comfortable negotiating pay and are less likely to consider that salaries are up for negotiation. The GPGiM survey showed that 72.8% of women doctors did not feel comfortable negotiating pay, compared to 54.4% of men. The data reveals that men are not only more comfortable negotiating pay but they are more likely to recognise the opportunity to do so.

- We believe it is important to have greater transparency around recruitment and pay, if a salary or terms and conditions are negotiable this must be clearly stated in the job description.
- We offer [existing resources](#) to help members with salary negotiation and engage, particularly, with salaried GPs and partner GPs.

*I was like, "Why are you charging less?" and I had a long conversation with one of them... 'It doesn't make sense, you know, you've been a GP for four years longer than me, you've got a lot more experience, I would expect you to be a lot more expensive if I was employing you, as a partner doing that.' M, 34*

## Shortening spine points

We support the recommendation to reduce the number of spine points for SAS and consultant contracts to shorten the time taken to reach the top of the pay scale. This is already a shared priority for the BMA management side in contract negotiations.

## Clinical excellence and performance payments

We have recognised that the current way that CEAs are awarded disadvantages women and BAME and disabled doctors, both for local and national CEAs. We are aware that part of the issue is women are not applying for the rewards at the same rate as men, when they do apply they have the same level of success.

In 2018, the agreed [guidance](#) between the BMA and NHS Employers on local CEAs included requirements to monitor applications and success rates by protected characteristic and, in agreement with the JLNC (Joint Local Negotiating Committee), to address any differences or discriminatory impacts identified.

Covid-19 impacted on discussions about allocation of funding for CEAs in 2020. In relation to this, the BMA and NHS Employers have recommended the funding is distributed evenly amongst eligible consultants. We recommend that consultant's working part-time should receive an equal share of the award money, rather than a pro-rated amount as they continued to be scored in the same way as doctors working full-time.

We are about to enter discussions about a replacement scheme for local CEAs in England with NHS Employers and the Department of Health and Social Care and will ensure the findings and recommendations of this review, and the need to narrow the gender pay gap are properly considered as we approach them.

We are currently undertaking consideration on possible measures to address inequalities in the national and local CEAs. We believe to address the unfairness in the CEA process the following points should be considered:

- LTFT doctors must be treated fairly and if their rewards are allocated on a pro-rata basis. This means their work should be assessed against other LTFT doctors rather than needing to meet the requirements of full-time consultants or if their contribution is assessed against full-time peers then their award should not be pro-rated. The GPG review recommends LTFT doctors' proportionate contribution should be recognised and they should be assessed against the proportionate hours they work. We already agreed this with NHS Employers in the LCEA [2018 guidance](#) (para 2.3) and we will challenge organisations who do not take this approach. We now need to ensure that national CEA process also makes similar progress on treating LTFT doctors fairly.

- we support the review recommendation that additional national awards fairly treat activities more frequently undertaken by women, such as mentoring or team leadership. These should also be incorporated into a replacement scheme for local CEAs, alongside activities more frequently undertaken by men such as additional such additional clinical, managerial or research activity. This will be taken into consideration in the upcoming local CEA discussions, with a view of analysing how feasible this is for practical implementation.
- evidence suggests that a significant reason for the gender pay gap in CEAs is that women are less likely to apply for them. We believe any new CEA successor scheme should consider automatic enrolment, as evidence suggests the gender pay gap is exacerbated by the fact that women are less likely to apply.
- improve gender diversity on CEA committees and ensure decision makers receive adequate diversity training.

As mentioned above, in 2018, the BMA and NHS Employers agreed guidance on local CEAs that requires applications and success rates to be monitored by protected characteristics and, in agreement with the JLNC, to address any differences or discriminatory impacts that are identified.

**BMA**

British Medical Association, BMA House,  
Tavistock Square, London WC1H 9JP  
[bma.org.uk](http://bma.org.uk)

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