This part, sums up the research in two chapter (Chapter 9-10), as Analysis & Discussion and Conclusion.
Chapter 9

ANALYSIS
AND
DISCUSSION
In this section we have analysed the data collected from the respondents according to our objectives of the study and verified our hypotheses. This section compiles socio-economic profile of the respondents followed by analysis of roles and responsibilities of couples, their decision making within family, their career path, factors behind the comparative success and failure and the policy suggestions for inequalities at work place.

Analysis and Discussion

In our present study we had the following objectives –

1. To study the roles and responsibilities of the couples in their family unit.

2. To study the decision making of the couple within their family.

3. To compare the career paths of doctor couple.

4. To identify factors behind comparative successes and failures that shape men and women doctor couples careers.

5. To offer policy suggestions that might remedy prevailing inequalities at the work place and home.
The following are the hypotheses keeping in mind the objectives of the study:-

1. In a dual professional family, men and women consultant doctors will equally share their home and work responsibilities namely education, employment and earnings.

2. Men and women consultant doctors will participate equally in decision making as they bring into their marriage equal resources namely education, employment and earnings.

3. Men doctors have few obstacles to success in their career than women doctors.

4. The family responsibility will clash with work responsibility for women doctors.

We shall first examine socio-economic profile of respondents followed by an analysis of our objectives.

**Socio-Economic Profile**

Our sample consisted of 160 consultant doctors or in other words 80 doctor couples. Both husband and wife did not necessarily have the same specialization.

Analysing the sample specialitywise, it was found that there was a presence of men in varied specialities especially in medicine, surgery while women were predominantly gynaecologist (68 out of 80). On further analysis it was seen that there was a marked gender wise distribution of doctors in the various medical specializations.
Certain specialities were seen as ‘masculine’ and certain as ‘feminine’. Generally, all surgeries (cardiothoracic, neuro surgery, cardio vascular surgery, orthopaedic surgery etc.) are dominated by men while mostly gynaecology and to an extent pathology is a woman dominated specialization.

We, then examined the work set-up of the doctor couples and found that most of them were running their own nursing homes.

The respondents were mostly in the age group of 41 to 45 years, followed by 36 to 40 and 31 to 35 years. Thus, in this age group, profession wise they have established themselves. Also, they still were in the child rearing stage of their life cycle.

Infact, the male and female age-wise distribution of doctors reveals that both men and women were concentrated in the age group of 36 to 45 years. In our sample, the age gap between a husband and wife was between 2 years to the most 4 years. Also in nearly each age group, there were on an average 14 couples who were of the same age. Being more of less of the same age means an interaction with each other at the same level and a fairly good mutual understanding of each other as they belong to the same age group.

Caste wise distribution of respondents indicates that most of them belong to high castes and are predominantly Baniyas followed by Punjabi’s and then Brahmins. Religion wise our sample had a predominance of Hindu’s and there was one Muslim couple too.
A majority of the couples have been married for 13 to 15 years followed by 10 to 12 years. On average men and women were marrying in their late twenties and early thirties.

Having been married for a decade or so means that they have established a set of roles and responsibility and decision making patterns. Moving on to the types of marriage, we find that our sample has predominantly traditionally united couples. However, out of our sample of 80 couples there were 35% in all, who had a love marriage in which most of them were inter-caste marriages. The women doctors who had a love marriage revealed how it was a trend with men doctors to court women, especially in the gynaecology specialization as they had an eye on the future setting up of a joint nursing home/private clinic. Of course, those in traditional marriages also took into consideration their partners specialization.

A large number of the respondents were practicing the small family norm and kept their family size limited to two children irrespective of the sex of the children. There were also couples who had an only child.

A majority of the doctors were living in extended families instead of nuclear ones. These doctors, thus, had a home support system for their children. 59% of the couples had the husband’s parents living with them. There were also doctor families with either a widowed uncle or aunt living with them or a brother and his family. However, these relatives were not financially dependent on them as they had their pensions or savings or income to support themselves. Our sample had a few parents who were doctors themselves.
Roles and Responsibilities of the Couple

The couples evaluated their spouses roles in seven different categories i.e. (i) As a provider for their physical and emotional needs (ii) As a financial provider (iii) As a family caretaker (iv) As a housemanager (v) As a sexual partner (vi) As a parent to the children and finally (vii) As a son/daughter-in-law.

Most of the doctors rated their spouses highly in various roles, excepting for housemanagers where the wives rated their husbands poorly. The items like financial provider and sexual partner were not negatively rated at all by the male and female doctors and they showed a high satisfaction rate for both of them.

Both male and female doctors rated each other good to average in their role of a son/daughter-in-law. Items like as a parent to children, family caretaker and provider for physical and emotional needs were rated good in almost equal measures by both the male and female doctors.

Not only that these evaluation patterns were further substantiated by their responses to other questions. When the doctors were in a problem, a majority of the doctors said that they first sought each other's support (whether the problem was work related, emotional or family related) and then figured out the course of action.

Also more female doctors always discuss work with their spouse regularly. In case of a 'bad' day at work, majority of the doctors talked it out with their spouses. Not only that a large
majority of the doctors promote each other's career by directing patients to each other, and thus are helping each other out in this aspect too.

More male doctors self evaluated themselves as having been successful monetary-wise as compared to the females. The majority of the doctors i.e. both male and female found their sexual relationship extremely satisfactory and jointly decided on family planning and spacing of the birth of their children.

A large number of doctors felt that they had played a positive role in their children's life as their children looked were proud of their parent's profession and wanted to emulate them. They also felt that their job had played a positive role on the lives of their children by primarily assuring them of a good financial and social status in the society.

When we examine roles we also look at the role conflict experienced by the doctors. A clear majority of the doctors said that the increased working hours and lack of leisure time was the major source of conflict for them. More female doctors found that their role of a home-maker was the next role conflict for them while more male doctors found the role of a parent as the second role conflict. Both male and female doctors agreed whole heartedly that their family responsibility clashed with their career commitment. Infact, many females feel that women, if they ever do lag behind men in career growth, than it would be due to family reasons.
Examining the typical daily home responsibility before going to work between the male and female doctors we find there is a clear demarcation of duties - the wives were mostly responsible for getting the children ready for school, while the husbands were dropping them off to school. There were certain tasks like tidying the house and supervising the servants which had zero participation from the male doctors side. Also there were a large number of doctors who said that they didn’t have any daily home responsibility and all they did was to get themselves ready for work and indicate to their family their meal preference for the day, watch the news, channels or just read the morning newspapers.

The female doctors had a larger share of home responsibilities to fulfill before leaving for work. The dominant one was the supervision of servants and giving them instructions for the days work. Also some of the female doctors indicated that they prepared the breakfast and tidied the house. More female doctors than male doctor said that their home responsibility consisted of attending to the need of her in-laws like giving/reminding them of taking their medication, doing small errands for them and checking on their day to day routines like morning walks etc.

Looking at the home responsibility of the couples after coming from work we find that for a majority of the doctors it was about checking the children’s home work and dealing with children related matters. More male doctors had the responsibility of picking up the children from school and some said that they did the household shopping on the way back from work.
A majority of the female doctors after coming back from work would mainly overlook and instruct their servants followed by doing household shopping on the way back followed by cooking food.

From the above responsibilities we can see a gender based division of work. Food preparation, tidying the house and supervision of servants is totally a woman task. Also many men have the luxury of not doing anything at all with not even a single woman doctor claiming so. However, the doctors did not admit to having a gender based division of work at home and said that they had a joint task sharing in their household.

More women doctors were able to relax more and have things done at a leisurely pace only during their work off days.

The physical aspect of housework in these doctor couples home was totally handled by the servants with the majority of doctor couples having full-time servants. Couples with small kids and infants had nannies on a full time basis. Also the doctor couples had part-time servants to do all the household work.

However a majority of the doctors although having both full-time and part-time servants involved their children in helping out at home. More male doctors said that their children have household tasks to perform like keeping their shelves tidy and their toys in order, rooms tidy, making their beds, bringing water for the guests or removing their plates from the dining table after meals irrespective of the gender of the children. These doctors said that it
was important to inculcate good habits in their children, though they were very strict about performance of these household tasks mostly during the school holidays. Thus we see fathers not helping out much in the household work yet having their children learn to help out.

After examining the daily routine home responsibilities we then examined the responsibility for household work on a selected list of 9 general items ranging from keeping the house tidy, to payment of bills, purchase of grocery and vegetables, purchasing of household utility stuff, buying items for home décor, attending children's school meetings, managing servants, purchasing gifts for relatives and looking after sick children and parents, we find no clear cut agreement on division of work. The females doctors are mainly looking after household activities and purchases while the male doctors are looking after payment of bills.

Looking after sick children, parents and dealing with matters pertaining to children's education is done jointly by them. There seems to be some sort of division of work in the household tasks with keeping the house tidy and maintained and supervising the servants as a totally woman responsibility and paying household bills as mainly a man's responsibility.

The male doctors are not able to spend much time with their children and during the time spent with them, more male doctors said that they helped them in their studies. The women doctors were on an average spending more time with their kids and were teaching them, but also doing things with them like watching cartoons,
playing, preparing their favourite food and involving them in smaller household activity as looking after the childrens need was according to the women doctors, their responsibility.

Moving on to the responsibilities towards parents we find it mostly confined to looking after their health followed by some doctors saying that there is no such delineation of responsibility as they would do whatever their parents asked them to. More male doctors had a close relationship with their in-laws while more female doctors had responded that their relationship was neither too close nor too distant with her in-laws. The responsibilities toward in-laws for the majority of the male doctors was nothing as such while the majority of the females responded by saying it was looking after their health. The other responsibilities cited by the female doctors were fulfilling the role of a good daughter-in-law by looking after their personal needs. The male doctors on the other hand, in small numbers said it was looking after their medical needs or looking after their financial investment related matters.

A majority of doctor couples said that they regularly consulted their elders on matters ranging from finance/nursing home/property to advice on social relationships to big family purchases and decisions related to children.

Thus, we find that our first hypothesis does not hold as personal resources namely education, employment and earnings do not result in the equal sharing of home responsibility. We find a gender based division of work in the doctors household though the doctors themselves were not admitting to it. Employment and
earnings result in having the ability to purchase the services of other people to look after the physical aspect of the housework and thus ease the life of the women professionals. Sharing of household responsibilities are along traditional lines with 'inside the house' work being a women's responsibility and 'outside the house' work being the man's responsibility though, we find an increased trend in joint task sharing between the couple which perhaps can be attributed to education and an awareness and understanding of each others profession and attendant work load.

The couples feel that compared to their parent's generation the husbands are treating their wives more as equals. Socialization into male and female roles along traditional cultural lines still seem to have a strong hold on the mental makeup of both male and female doctors.

Examining the roles and responsibilities of the couple at the workplace, we find that though the men and women doctors are working in the same nursing home/private clinic, yet here they take care, individually of their work responsibility namely looking after their patients, handling their staff and making financial decisions (on patients bills, giving them discounts etc.)

Only in extreme cases do men and women doctors help each other in the above work responsibilities, otherwise they do not interfere in each others work, also when a second opinion is needed immediately, they discuss with each other first before seeking advice from other doctors.
As, mostly the husband’s specialization is related to medicine or surgery, it is seen that more women gynaecologists preferred to first consult their husbands for certain complicated gynaecological cases, when requiring the expertise of that branch. Husbands rarely consulted their wives as the wives speciality was gynaecology. Any purchase of equipment and other items for the work place is done by the concerned male or female doctors, however the financial negotiation of the purchase is mostly handled by the male doctors. Also any medico-legal cases are mainly handled by the male doctors.

Thus, we see at the workplace, the men and women doctors are like two professional individuals, who fulfill their professional responsibilities. Here our hypotheses is validated.

Decision making of the couple at home and at workplace

Who mostly makes the decision in the home front was what we are looking into as this reveals the power equation between the men and the women. When we examine decisions pertaining to the household domain we find a certain pattern emerging.

In the listed categories of decisions regarding the household domain, we find a joint involvement of the male and female doctors, though in some decisions one can see a dominance of one gender.

By themselves men do not get involved in decisions pertaining to the supervision of servants and purchasing of small items. Rather, they dominate in mainly making decisions regarding big purchases, investments and geographical relocations.
Women on the other hand have the responsibility of managing the running of the house and so make the decisions by themselves on the matters pertaining to it. On the other hand, individually, no woman took decisions on big item purchases (car, property etc.) rather it was a joint decision according to them. Decisions regarding leisure-time utilisation and kin/relative responsibility had a dominant joint participation.

Thus, we see a pattern wherein house related decisions are in the wife’s hand while decisions involving the spending of a large amount of money are in the husband’s hand.

The next set of decisions that we examined were those related to children. Decisions on family planning i.e. when to start a family and how many children to have and the spacing of the birth of the children were mainly joint decisions.

Again, although both husband and wife make the decisions jointly we find the husband’s/wife’s dominance in certain decisions. Ownership of material goods (kinetic, mobile, music system, expensive toys) and pocket money decisions have majorly a male influence, while decisions regarding children’s education, sorting out their social relationship issues, enforcing curfew hour’s, fixing pocket money, overseeing their free time activities and teaching them about life values have a female dominance. Thus, we find men handling decisions related to money mainly. On the other hand, women were overall making more routine decisions for their children by virtue of being more with the kids.
When it comes to socialising with friends we find that owing to the hectic work schedule of the doctors, they are able to socialize at least once a month and that too with the husband’s friend circle rather than the wife’s. Even though both husband and wife are from different specializations, yet the husband’s friend’s circle is given more prominence. Similarly, most doctors are able to visit their relatives mostly on the husband’s side of the family, once a month and that too on special occasion. This was not only due to their work schedule, but also due to the fact that the husband’s relatives are mostly residing locally.

When the men and women doctors were asked who was more dominating in their marriage, both said that it was the man. More women doctors said that they had made all the adjustments in the marriage as their husband said they can never change.

We then asked the couples what things they would like to change in their spouse as these issues must be causing some disagreements in their life. Being more financially savvy was the most desired trait for both male and female doctors, followed by having the ability to control the temper and bring about a change in irritating personal habits. Women mostly wanted their husbands to work on their financial handling skills while men wanted their wives to work on their temper though the issues on which they lost their temper were due to the personal habits of the male doctors like chewing pan masala, tobacco, smoking, drinking, poor dietary habits, their friend circle, lack of punctuality and poor time management. We wondered if this meant that the husband and wife
had a list of restrictions that is do’s & don’ts on each other as this would translate into dominance of one spouse over the other. More male doctors said that their wives had a list of restrictions on them and these were mainly related to their time management, personal habits and financial management. A majority of the females said that they had no restrictions imposed on them by their husbands.

When it came to handling issues on which the men and women doctors disagreed on i.e. mainly time, its utilisation and money we found a majority of the couples saying that they handled the issues through mutual discussion. Issues on time and its utilization were major grouses that wives had against their husbands, which the husbands were aware of and a majority said they handled these issues by adjusting their time and work schedule.

Money is important in any relationship and as our data has shown, large amount of money spending is more of a husband decision. More women said that they seek the approval of their spouse before they splurge on personal luxuries. However, when it comes to saving most men and women like to maintain separate savings accounts.

So, overall when it comes to decision making, though it was more of a joint participation, there were certain areas in which the male influence was more as compared to the female influence. Decisions regarding money matters i.e. matters of significance were mainly in the husband’s domain while decisions regarding home management (routine decisions) were mainly in the wife’s domain. Matters related to big money spending though jointly discussed,
were never seen to be taken individually by any woman. This pattern remains the same even after many years of marriage. Also, as women had the responsibility of home management, they took decisions pertaining to it and there was no husband interference. Examining their other routine decisions, we find women making more day to day decisions for their children by virtue of being more with them. However major decisions like possession of goods, education etc. had a slight male dominance.

Relating decision making to the number of years of marriage, we find that in the initial years of married life (0 to 4 years), decision making was highly segregated. However, between 4 to 12 years or so of marriage (i.e. during the early stage of child rearing) we find that men become more participative in the decisions related to the house and children though they never individually take the decisions, they show more of a joint participation.

After 15 years or more of marriage, the same kind of decision making pattern as observed in the initial years of marriage seen. This may be due to the fact that children responsibility has decreased to an extent and they no longer require that much supervision.

Decision making is also dependent on the family structure, with more joint decisions in household matters in nuclear families and segregated decisions making in extended families.

Thus, overall we find the decision making pattern varies over the years of marriage, rather it becomes more joint in matters pertaining to household and children but remains the same in other
matters like money. Examining decision making pattern made individually, we find men are making overall, more decisions and significant ones while women were making more routine decisions. Thus, decision making as such is not shared equally and so our hypothesis does not hold.

When it comes to making decisions at the workplace we find that both male and female doctors take their own decisions in terms of patient care, handling of staff and taking financial decisions. Only in case of emergencies do they seek each others help. Here financial decisions regarding patients i.e. the medical bills, discounts are taken by male and female doctors separately.

However, medico-legal cases are mainly handled by the male doctors. Also any purchase of equipments and other items for the workplace is chosen by the concerned male or female doctor whereas the financial negotiation of the purchase is done by the male doctors or the head of the institute. As the years of work experience increase, we find men and women doctors leaning towards a participative and joint decision making in matters pertaining to staff management and finance. The doctors began to take decisions on these matters on each others behalf.

So, overall we find that at the workplace the men and women doctors are operating as individuals. Both are having equal educational qualifications and both are operating as professionals and thus do not have a traditional gender equation between them. Moreover, as couples, both men and women doctors go out of their way to further each others career and do not have any professional
rivalry even if the wife is earning more than the husband as they focus on the net income that is accruing to them. Thus, we find our hypothesis hold as men and women are equally sharing work responsibility.

At the home front we find a traditional gender equation between the male and female doctors, though a majority of the couples said that their generation has more of an equal relationship between the husband and wife as compared to their parents. This they attributed to better education and awareness of home and work responsibilities.

More couples agreed that at home the husband or men dominate, as to a certain extent they follow the traditional cultural pattern of male and female role and responsibilities. Decisions, though taken by both, have certain domains that are the prerogative of the male and female by virtue of their role and responsibility and cultural habit.

To compare the career path of the doctor couples

We wanted to find out the way men and women doctor's career takes shape. Different specialities tend to have different configuration of male and female doctors in it so much so that particular specialities see the dominance of men and are seen as 'masculine' specialities while others have a dominance of women and are seen as 'feminine' specialities.

Specialities like gynaecology are women dominated while all types of surgeries are men dominated.
When we examine the career path we shall be taking into consideration the average working pattern of the male and female doctors. The number of hours worked, taking into consideration the nature of specialization, shows that both men and women doctors are working longer hours than their ideal. More women doctors as compared to men were putting in more than 12 hours of work daily, as being gynaecologists, their working hours were stretched as they were looking after their indoor patients and doing deliveries apart from their daily OPD’s.

The type of specialization also determines whether the doctors would be taking night calls regularly. Doctors like pathologists, ENT’s & Opthamologists don’t have night calls. Otherwise, both male and female doctors take emergency night calls. Women take night calls only from their own private setup while men take night calls from all those setups with whom they have a working agreement. In the case of home visits a majority of doctors don’t take on any and prefer to see the patients at their nursing home citing lack of time. Those doctors who do take home calls do it because of their personal acquaintance.

While the female doctors working pattern was confined to their own nursing home, the male doctors visited their indoor patients in different nursing homes and did their operations and spent time with critical patients in ICU’s after their OPD timings. The number of nursing homes visited is dependent on the chosen specialization of the doctors and their business tie ups with other nursing homes. More male doctors are working in more than one
set-up, while the female doctors mostly work for their own set-up. Also, as couples have their own work set-up, they have joint nursing homes ownership.

The average number of patients seen by a doctor in a day is indicative of the success of their practice. In general male doctors are seeing more patients in their OPD’s in a day than female doctors. The female doctors mostly gynaecologists end up spending more time with their indoor patients.

Paper publishing is indicative of the doctors academic inclination as well as their orientation to research. Although more male doctors had their papers published but there was a sizeable number of both male and female doctors who had never had a paper published. These doctors felt that excelling in their craft had no link with the number of papers published.

Attending conferences are a part of a doctor’s life. All doctors attend conferences at the local level. These are normally organized by pharmaceutical companies or by their medical associations and hence are specialization specific. Those conferences that are held outside Agra, though being specialization specific are attended jointly by a husband and wife. Otherwise, by themselves, hardly any women attends these conferences.

Thus, overall we find men and women equally matching up their working skills.
As regards to income, well the individual income is not revealed by the doctors as these doctors are earning income from different sources and pooling all their earned money with their spouse.

Next we asked the doctors if they had experienced discrimination during their career. More male doctors said that they had experienced discrimination while on the other hand a large number of women said that they had never experienced discrimination.

The most common form of discrimination experienced by male and female doctors is on caste, followed by discrimination on regional basis and gender basis.

The discrimination in the medical profession is seen in the form of providing exposure during post graduation in medical college, helping upcoming doctors during their early career stage, referring patients for consultation, sending patients for diagnostic tests etc.

Women doctors who are working in their own set-up said that they experienced discrimination when they went out of their set up to learn new things from others.

Finally, we asked the doctors about their perception regarding male and female doctors career growth. Both men and women doctors feel that career wise women do not lag behind men. Their perception was that especially in the medical line, both men and
women have equal chances of growing in their career. In cases where they do lag behind then, primarily it is because of their family responsibilities. Thus, we find both men and women doctors equally holding forth and matching up with each other.

We had hypothesized that men doctors will have few obstacles to success in their career then women doctors.

Referral of patients, role of non qualified medical practitioners, casteism, regionalism, malpractices, patients attitude, professional jealousies vis-à-vis other doctors and other such obstacles were found to plague both men and women doctors alike. Profession wise both faced the same kind of obstacles irrespective of gender.

Individually women doctors found that in certain varying degree their home responsibility had impacted in their career as they cited that constant updation of knowledge was not always possible for them. Also as they were mostly working in their own setup they experienced discrimination only when they went outside their setup to learn new things from others.

For the men doctors, they found that basically they were not able to have the infrastructure according to the services they had visualized to provide. Also the poor paying capacity of the patients was to a certain extent hampering their expansion plans as they had to look into providing facilities on the basis of the patients affordability.
Thus we find both men and women doctors experiencing the same type of professional obstacles. However, women doctors have family, children responsibility which does impact their career in varying degree. Hence men doctors have few obstacles to deal with as compared to women. Hence our hypotheses is validated.

Factors behind comparative successes and failures that shape men and women doctors career

For a doctor, choosing his or her specialization has a crucial bearing on their professional life. On examining the distribution pattern of male and female doctors in the various specialities we find a gender-wise distribution of the doctors in the various specialities. Certain specialities are seen as ‘masculine’ like general medicine and generally all types of surgery, neuro surgery and orthopaedics. Others are seen as specialities suited for women, predominantly Gynaecology and to an extent Pathology.

The doctors gave different reasons varying from the inherent male and female mental strength and temperament to social acceptance and consequently pecuniary benefits. Specialities like gynaecology are seen as a feminine branch which is not only lucrative but also a socially acceptable branch for women. This fact motivates many women to opt for gynaecology. Men on the other hand are able to select their specialization relatively freely than women as the societal mindset doesn’t harbour restrictions on them. Infact men are easily able to establish themselves in any specialization even the so called feminine, specialization like
gynaecology. Among the leading gynaecologists of Agra, there are many male doctors.

Women on the other hand are not able to establish themselves in the so called 'masculine' domains as societal mindset is such that patients prefer to consult a male doctor rather than a female doctor. The response rate of the patient is very slow towards women doctors and it takes a long time for them to establish themselves in the so called masculine specializations.

There are also certain specialities that are comparatively women friendly like paediatrics, anaesthesia and opthamology but these specialities do not have the patient pull towards them like gynaecology. Overall, it was found that societal acceptance and market economics (i.e., specialization viable monetarywise) influences women's criteria for a particular specialization while personal preference dictates men's choice of specialization.

As for running the practice, it is important to have a steady flow of patients. Rural patients have a rigid mindset regarding men and women doctors capabilities, mostly reposing their faith in male doctors.

As these doctors also get referred patients from (General Practitioners) GP's and (Regional Medical Practitioners) RMP's, a good PR network is also found to be an important factor on getting patients. Most of these negotiations are done by male doctors.
Casteism, regionalism, religion and gender have an inherent effect on the ability of doctors to practice their trade. Patients tend to patronize doctors of their caste. Not only that doctors prefer to refer patients to other doctors of the same caste as theirs. Also patients prefer to consult doctors with the same religious affiliation as theirs. Muslim and Christian doctors being in the minority, the patients of these religious group than tend to enmasse patronize particular doctors, that is those doctors who are able to win the goodwill of that community.

Similarly, it has been found that patients patronize doctors of the same region or village as theirs.

Women doctors on the other hand have numerous times found that winning patients confidence in specialities apart from gynaecology require a lot of time, as the patients mindset is such that they prefer to consult male doctors rather than female doctors.

Not only that, in the case of women doctors, their responsibility towards their family at some stage of their life cycle does in varying degrees have an impact on their career. However, the women doctors said that they have greater leeway in this profession to manage both their professional and personal life due to work-schedule flexibility. Apart from these, the other obstacles to career success strongly felt by the male doctors were the absence of basic infrastructure hampering their efforts to provide quality services. Also non-qualified medical practitioners were stalling their growth and the medical line in general.
The women doctors felt casteism and its resultant patronage by patients and doctors alike hampering their career growth. Also the women doctors said that the problem of constant updation of medical knowledge was not possible as they were tied to family commitments.

Finally, those doctors who belong to the second generation of doctors families were at an advantage as they get the basic infrastructure and an established practice from their doctor parents which obviously the first generation of doctors will take time to achieve.

We had hypothesized that family responsibility will clash with work responsibility for women doctors. It was found that both men and women doctor agreed that career-wise women doctors do not lag behind male doctors. If they do, then basically it is because of their family responsibilities, which occupy a major portion of their lifecycle.

The women doctors felt that they had to compromise quite often with their work due to their family demands. However, as most of them were living in extended families, having nannies, having work-schedule flexibility, this aspect was managed to an extent. Also, since they mostly had their own nursing homes and private clinics they felt that apart from their profession this factor also gave them greater leeway in family management. Even their husbands would arrange their work timing and operations to look after the family needs when need arose. We did not find a single women doctor who had discontinued her practice because of her
family commitments. Rather, they would scale down their practice, but still continue working. Thus, we find family commitments impacting in varying degrees.

Also, women doctors due to family commitments, couldn’t regularly attend CME’s (Continuing Medical Education) for updation of their medical knowledge. Between the couples there was an implicit understanding that where family management is concerned, it is the woman doctors responsibility and not the man’s and hence women doctors in fulfilling their family commitment demands had to sacrifice their careers.

So, overall, family has an impact on the women’s profession, it does clash with their professional role in varying degrees as it occupies a major portion of their lifecycle. Thus our hypothesis does hold true in the case of our respondents.

Policy Suggestions that might remedy prevailing the qualities

We asked the doctors if the National legislation is inadequate in dealing with the gender discrimination problems at the work place and whether there is a way to erase gender discrimination.

A large number of women doctors agreed that the legislation was definitely inadequate in dealing with gender discrimination. Most of the women felt that the government can’t do anything about it as it is ingrained in the men. Some women attributed it to the Indian culture and were pessimistic about change. Some male doctors said that it was not the government’s problems but a social problem and stigma. Most of doctors said that it was the people who
have to change. Some change can be brought by improving the educational status of the people.

There were a few women doctors who said that the work can’t be done by the government alone as there are many grey areas of misbehaviour and moral let down between the extremes of sexual harassment and a very comfortable work atmosphere.

The male doctors felt that the law was adequate in dealing with gender discrimination at the work place. There were 42 (i.e. 26 male and 16 female) doctors who said that they had no idea.

We put a next question to the doctors whether the government should enact family friendly policies and legislations especially geared to meeting the requirements of the working couple as more and more couples are becoming dual earner’s in today’s time. A large majority of the couples agreed. More male doctors said that they should be made to places where there are good educational facilities for the children.

Both men and women doctors felt that there should be some sort of a special privilege or policy but were not able to delineate it. Also some couples talked about offering priority to working couples in the government department in terms of promotion’s transfer’s etc.

There were 20 doctors who felt that there was no need for any such policy while 19 doctors admitted that they did not have an opinion on this.