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Gender challenges within the UK Defence Medical Services: recruiting and retaining a diverse workforce

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ABSTRACT

While there are women represented in some notable positions within the UK Defence Medical Services (DMS), the challenges and barriers to successful female progression have not disappeared. The DMS needs highly talented, motivated doctors working to support operations, yet we struggle to recruit and retain female personnel. This is in clear contrast to the increased proportion of female personnel working within the civilian medical workforce.

This article seeks to communicate this problem, illustrated by the lived experiences of DMS female doctors, by exploring the six gender bias barriers ('Glass Walls') that hold women back in the workplace.

Cultural change requires a determined effort, driven persistently from the top and at every level of leadership and management. The first step requires recognition and acceptance of the problem. Progress is likely to be slow, or fail, if driven by the female minority alone. While the DMS remains a majority-male organisation, male allies are pivotal in advocating for their female colleagues, to promote change, in an effort to recruit and retain talented individuals.

INTRODUCTION

The appointment of the first female 3* Director General, supported by a female 2* Director of Personnel and Training, and two female Single Service Medical leads might indicate that equality has been achieved within the UK Defence Medical Services (DMS). However, a small number of women breaking the glass ceiling is not necessarily representative of female progression and does not mean that gender-based challenges and barriers have disappeared. It remains critical that our personnel understand this problem and that our organisation continues to work towards gender equality.

This article specifically considers the issue of gender equality from the perspective of female doctors within the DMS. We describe six gender bias barriers—'Glass Walls'—that persist in holding women back in the workplace[1], illustrated with quoted lived experiences of DMS female doctors. This work should not be considered empirical research; our aim is to report the problem, evidenced in scientific literature and by statistics, to break barriers and encourage further research. This article has been challenging to write and may be difficult to read, but we hope to encourage thought and trigger conversation across our community.

The Ministry of Defence (MOD) aspires for 30% female inflow to the UK Armed Forces (UKAF) by 2030.[2] In October 2023, 11.7% of the UKAF and 14.7% of officers (OF1–OF5) were female, with a marked fall in representation with increasing seniority, with just 8.1% of senior officers being female.[3] As more females are leaving the regular UKAF than joining[3], recruitment alone will not increase the proportion of women serving; there must be a concurrent focus on retention. MOD recognises that culture and behaviour change towards inclusion are vital.[4]

The civilian medical workforce has an increasing female majority[5] and this 'feminisation' has been considered a concern for the DMS.[6] In the 2022 cohort of medical officers commencing general duties, 32% were female, compared with 57% nationally at a similar postgraduate stage.[5] Retention is equally problematic. Female doctors are less likely to become consultants and more likely to leave medicine entirely.[5] Female service personnel in the USA serve for shorter time periods and report less satisfying careers than their male counterparts.[7] Retention rates within the DMS specifically are unpublished, but it could be argued that the same issues exist.

UNDERSTANDING THE PROBLEM

There are known, evidenced, individual, systemic and organisational behaviours that promote gender imbalance.[1 8] The impact of these behaviours was notable in the National Health Service (NHS) 'Me Too' movement, with reports of sexual harassment and sexual assault reported by the UK media[9–11] and in peer-reviewed journals.[12–15] This has led to increased efforts to remove inappropriate behaviours from the NHS.[16 17]

Females are under-represented in senior and leadership positions in clinical and academic medicine.[18] A 2023 US military study concluded that women have not achieved promotion to the highest levels of rank, military, or academic leadership at the projected rate compared with their male colleagues.[19] The MOD recognises that improving its own female senior representation may take between decades and 300 years at its current trajectory.[20]

Even when females become well-represented in a field, gender biases and inequality persist, which is predominantly noticed by women.[21] As men are less likely to recognise gender bias, their support for gender equality initiatives may simply, and systematically, differ.[21] Many attempts to address gender bias are seen to disadvantage those who benefit from the current status quo. When competing for positions, it is difficult to take an altruistic approach to addressing inequality when this action may result in the loss of an advantage.[1 22]

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GLASS WALLS: SIX GENDER BIAS BARRIERS

Scientific inquiry has identified six gender bias barriers that persist in holding women back in the workplace: male privilege, disproportionate constraints, insufficient support, devaluation, hostility and acquiescence.[1] These 'Glass Walls' have been interpreted with DMS context. The women who provided the quotes used in this section voluntarily contributed their experiences through discussion with the lead author and consented for their words to be published. They represent all three services, a range of ranks (OF2–OF5) and medical specialties, both serving personnel and veterans. Their words are illustrative of the problems, but they do not intend to represent the views of all DMS female doctors.

1. Male privilege: components that exist to perpetuate the male culture for the benefit of men. Examples include male gatekeeping, where male superiors determine which females have access to leadership positions; informal conversations and social activities that intentionally or unintentionally exclude women; masculine language, which reinforces ideas and norms about who belongs and symbolic tokenism.

Hierarchies are diminishing in civilian medicine but are necessarily inherent in the military. However, where an authority gradient exists, it typically favours men, leading to an increased (and frequently unhindered) risk of sexual misconduct.[14] This issue is pervasive throughout medicine, with strong evidence that sexism and misogynistic cultures are present in many workplaces.[12 23 24] Gender imbalance becomes even harder to address due to the lack of senior women.[8] The 2021 'Atherton Report'[20] criticised the culture of the UKAF as 'still a man's world', stating that female service personnel face additional challenges to their civilian peers.[20] Although women can serve in all military roles, this is not necessarily because they have been readily welcomed, with reports that leaders have at times felt coerced to drop objections to their inclusion.[25]

> A senior colleague said to me: 'There isn't a problem for women in (defined specialty). Look at you, you're here, and you're doing fine' but it feels like that minimises all the difficulties I've experienced to get here. It also makes me worried that female trainees will think they need to be just like me to be successful… and I've made choices that not every female would be comfortable with.

Tokenism presents two conflicting messages: 'you are only here because we need a woman' and 'you are the only woman qualified to be here'. This aspect is one the DMS risks perpetuating, especially as individual female officers achieve senior posts. There is often little recognition of the journey navigated to that position or the sacrifices made. Token women feel uncomfortable with both the heightened visibility and subsequent invisibility. They risk any failure becoming highly visible and that failure being used to justify keeping women from the positions in the future.

> We had a joint career interview…to enable us both to have the opportunity to progress our careers over time…we were happy to compromise. The interview essentially consisted of me being told what he would be doing despite the fact this would mean I could not progress. The message was 'we're investing in him not you'. Quite apart from the fact this disadvantaged him in terms of participating in family life, I was senior at the time but my career was not seen as worth the organisation supporting.

56% of married UKAF female personnel are in a dual-serving relationship, compared with only 5% of married male personnel.[20] Medical training, different assignment locations and deployments mean that serving military couples are likely to spend significant time apart, resulting in difficult lifestyle compromises, disruption and loss of their support network, creating a differential ability to take up career opportunities. Family sacrifices are both individualised and culturally driven, but women continue to have differential expectations of their role in a family unit compared with men.[26]

2. Disproportionate constraints: different career choices and unequal standards regarding their work output and behaviour. Although a given career choice within DMS may not be a significant barrier, there remains a requirement to address unequal standards. Females are perceived to have less leadership potential than men, despite having higher performance ratings.[24] Women in academic medicine are less likely to be promoted and constitute the minority of research authorship.[18] One (of 11) DMS Clinical Impact Awards was awarded to a female in 2023. Women are considered less competent[21] and slower to attain clinical competencies.[19] Marital status and parental responsibility are significantly associated with the likelihood of exam failure for female surgeons.[27]

> Sometimes I feel like I can't ever do the right thing. If I choose a posting that allows me to be near my family, I'm a bad feminist and if I choose a posting away from my family, I am a bad wife/daughter. I don't see the same criticism of my male colleagues' decisions.

Pregnancy and maternity leave are considered problematic in the military[28] and in medicine.[29] Time out of work to birth and care for children creates a disproportionate constraint on the female workforce.[29 30] Having dependent children is an important reason why women leave the UKAF, and increasingly likely if they are in a dual-serving relationship.[20] Female doctors have a lower rate of childbirth than non-doctors, have higher rates of complications and tend to start families later in life, deferring pregnancy until training is completed.[30]

> Not once has my husband been asked what we do for childcare to enable him to fulfil his military role. It is often the opening line to me with the undertone that not being looked after by their parent places my children at a disadvantage.

3. Insufficient support: differential access to communal resources, mentoring or sponsoring activity, or unsupportive leadership and exclusion from opportunities and events. Mentors are experienced professionals who provide guidance and support to peers or junior colleagues. Sponsors are higher-ranking individuals who advocate for and provide opportunities to others. Both are critical to advancement, yet women are less likely to access either. There is a recognised double-bind for women who do promote themselves, as they are likely to be penalised for appearing too ambitious or self-promoting in comparison to similar behaviour in men.[31]

> I can recount a number of times where I've received comments about my interactions with others. The message is 'don't be too pushy'; be competent, but not too ambitious; be direct, but don't be a bitch. It's a difficult line to walk.
>
> A potential sponsor told me that I could have a great future and had huge promotion potential, but I needed to choose what came first, my career or my family. I was dropped when I opted to put my family first.

In the UK, childcare and other forms of unpaid household and care work are considered women's responsibility, perpetuating the fallacy that men are not interested in altering the balance of work and family. Flexible working and shared parental leave policies have been introduced in the UKAF, yet are predominantly used by female service personnel.[32] Caring responsibilities limit the ability to extend work beyond core hours and reduce opportunities for networking. These directly and indirectly

Table 1 Recommendations to support female inclusivity within the medical workforce, summarised from literature evidence[1 18 35 38]

Listen	Begin with listening to the experiences of the women around you. Make efforts to understand the issues they face. Male allies in the Armed Forces, medicine and academia have a significant role to play in effecting change and ensuring equity.
Lead by (Good) Example	Everyone is responsible for ensuring that there is no space for bias, discrimination, hostility or sexism of any kind. Leaders can make the most significant difference by addressing issues at the point of occurrence before they reach an unacceptable or intolerable level. Those affected should report using the pathways available and be supported to do so; this may require bravery and trust.
Be Objective	Objectively evaluate gender equity throughout all departments and sub-divisions. Consider if there is a lack of female representation and actively ensure equitable access for all those appropriately qualified. Single loud voices (of any gender) should not dictate action.
Advocate	Encourage all personnel to use policies that support work–life integration to reduce the likelihood of individuals needing to choose between career advancement and their personal circumstances. Avoid commenting on their decisions unless there is an explicit operational need.
Connect	Females are more likely to report personal and professional isolation from their colleagues. Offer formal and informal networking opportunities which are accessible. Encourage female representation. When engaging in mentoring, consider your own potential biases regarding whom you choose to work with.
Support Development	Women are more likely to receive subjective feedback rather than objective, constructive and actionable points. Consider the content, intention and timing of delivered feedback. Challenge your delivery. Consider whether the same feedback could or would be given to everyone.
Include	Ensure women are invited to the table, valued and respected. The system may currently struggle to accommodate women. It is important that women within the organisation do not see the sacrifices that they may have made as the only way to do things. If the true aim is meritocracy and inclusion, we all have a part to play.

create a disadvantage by contributing to the emotional load, the risk of burnout[29 30] and the gender pay gap.[8 21]

4. Devaluation: diminishment in the form of put-downs, belittling or condescending remarks; 'un-titling' whereby first names are used rather than females' title or rank; minimisation of workplace contributions and assumption of responsibility for administrative duties ('office housework').

> Myself, and a male colleague of the same specialty and rank, were allocated responsibilities at an event. He was told to organise the guest list, transport and visitor passes, I was to organise the catering, and make sure I get 'the good biscuits.' I did question what it was about us that led to roles to be allocated in that way… which was met with silence.

> I don't want to be 'Superwoman' for daring to combine work and family life. My male colleagues do it too. The title means that any mistake or deviation from an expected trajectory is seen in a much more negative light than my peers due to my 'audacity' at not conforming to the expectations of others.

Benevolent sexism consists of seemingly positive compliments that perpetuate gender stereotypes about women. Individuals who endorse benevolent sexist attitudes are more likely to support gender equity policies, but only when women are perceived as sufficiently feminine and recruited to feminine, rather than masculine positions.[1 8] The insidious nature of benevolent sexism is difficult to overestimate and contributes to the career success of female military personnel in complex ways.[7]

5. Hostility: discrimination, where women are denied opportunities or equal pay due to gender; harassment, including verbal abuse, bullying, sabotage and sexual misconduct; female hostility, due to women's learned mistrust and prejudice against other women and retaliation, where women are punished for reporting. The MOD report on Inappropriate Behaviours stated that 12% of Armed Forces personnel had been subject to bullying, harassment or discrimination in the previous 12 months, yet only 6% made a formal complaint.[33] Key reasons for not reporting were a lack of faith in the process and a belief that a complaint might adversely affect their career.

> Fear of retaliation from colleagues, male and female, makes reporting things that shouldn't be happening very difficult. If you try and 'nip it the bud' you are over-reacting. If you wait until it is utterly intolerable you 'should have spoken up earlier'.

There is a fine line between banter and bullying. Males are less aware of the type and extent of banter that can be experienced as negative and the impact this language can have.[14 34] Banter can explain away unconscious prejudice and misogynistic behaviours as innocuous jokes[35], but it is also a means for (future) perpetrators of unacceptable behaviours to test boundaries and desensitise others.[36]

> I experienced what I now recognise as gendered bullying while I was deployed, to the point where I later needed psychological support. The perpetrator was a senior officer, who was eventually removed from the post, but for other failings. When I suggested to my CO that I wanted to report his actions, I was advised not to as 'we wouldn't want to ruin his career'. My line manager told me to forget it, as reporting it would make me seem weak.

6. Acquiescence: manifesting in the form of self-blame, self-silencing and self-limiting aspirations. This occurs when barriers are so prevalent that women internalise them, accept them as valid and adapt to the limitations of their environment. Many women will be able to tell stories of acquiescence, but perhaps the most pertinent data will come from those who felt it necessary to leave. Those remaining in service may represent a survivorship bias of females more willing and able to acquiesce. The identity of a military woman has been characterised as 'deeply odd', conceptualised as having both an insider and outsider role in the military and wider societal culture, due to not meeting gendered stereotypes.[37]

> I don't think I realised how bad it was until I'd left. There were so many things, behaviours, that I considered normal. I really thought I was the problem, that my face just didn't fit. Leaving the military was like recovering from a kind of Stockholm syndrome. Don't get me wrong, I'm really glad and proud to have served, but I now look back on some of those experiences and wonder how different it could have been.

RECOMMENDATIONS FOR ACTION

It is not outlandish to say that 'men and women are living different realities'[14] and that the glass walls need to be addressed for women in the DMS. Cultural change requires a determined effort, driven persistently from the top and at every level of leadership and management.[33] At the 2024 DMS Research and Clinical Innovation conference, Professor Lucy Chappell, Chair

of NIHR, stated that it was 'the responsibility of all of us to fix the system' if it was broken – there is no better time for action than now. Fixing it requires recognition and acceptance of the problem. Applying a gender-blind approach means all personnel are expected to behave in the same way. However, if the majority are male, this makes traditional male behaviours 'the way'. This is not inclusion; this is acquiescence with room made for women only if they overcome their own differences to the male norm. Simple, evidence-based recommendations to promote inclusivity are summarised in Table 1.[1 18 35 38] The aim of these is to educate, promote and support the advocacy work already being done by allies within our organisation.

While this article focusses on gender, people of colour and those with other protected characteristics will be affected by similar challenges, and the intersectionality of multiple factors causes more significant disadvantages than anyone alone. Visible representation and role modelling of inclusive behaviours help promote equality for all minority groups.

CONCLUSION

The Defence Medical Services remains a male-dominated environment and the success of the visible women within DMS should be championed. Key to cultural change are our male colleagues who can advocate for women and promote working practices devoid of gendered advantage. Minority females are insufficient in number, seniority and visibility to drive this change alone. Future research to explore gender challenges relating to recruitment and retainment will promote the longevity of our DMS workforce and ensure that individuals of all genders are supported.

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Author biographies The authors' collective experiences span many years and different medical specialities, with varying experience regarding motherhood and involvement in dual-service relationships. Surgeon Lieutenant Commander **Cara Swain** is a higher specialty trainee in general surgery, and a Senior Military Academic Clinical Fellow in Surgical Education. She joined the Royal Navy in 2009 as a medical student. In 2022, she established an organisation for Royal Navy Medical Officers called the Royaumont Forum, which aims to promote collegiality and provide support for all, especially to those in training. Surgeon Commander **Charlotte Evans** is a consultant psychiatrist, and previous Royal Navy Consultant Advisor in Psychiatry and Royal Navy Hudson Fellow. She joined the Royal Navy in 2003 and is an active patient advocate. Her research interests include occupational outcomes in military mental health patients and the interface of mental health and illness with military strategy and policy. Captain **Victoria Kinkaid** is a general duties medical officer in the British Army, who initially commissioned into the Reserves in 2017. She is the Army lead for the Defence Women's health special interest group and a human security advisor. Victoria is a feminist and activist, campaigning against the practice of Female Genital Mutilation (FGM) and advocating for women's healthcare and empowerment, and founded the Virago Voices podcast in 2020. Surgeon Captain **Jo Keogh** OBE joined the Royal Navy in 1996 and trained as a radiologist. She is the former Commanding Officer of Joint Hospital Group (South West) and currently Assistant Head of Strategic Commissioning for Defence Medical Services. She is involved with multiple organisations in support of military personnel, including the Haywood Club, Royaumont Forum and as a Trustee of the Royal Navy Royal Marines Charity. Colonel Professor **Linda Orr** OBE joined the British Army in 1988, and is a consultant ENT (Head and Neck) surgeon and incumbent Defence Professor of Surgery. She is the UK Defence representative on the UK Federation of Surgical Specialty Associations and is the Royal College of Surgeons of England Surgical Research Advisor. Retiring in late 2024, Linda has focused her attention during her tenure as Defence Professor on ensuring more junior medical officers have access to academic opportunities. Surgeon Captain **Katherine King** is the Head of Academic General Practice, and a practicing GP, with a wide range of research interests. She joined the Royal Navy as a medical student in 2000. Kate is an advocate for women's health and women's wider experiences in the Armed Forces, sitting as a member of the Serving and Ex-Serving Women's Health Improvement Group.

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