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WORK AND THE CONJUGAL FAMILY

A study of the inter-relationship between work and family in the life-interests and life-plans of hospital doctors and general dental practitioners

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Doctor of Philosophy
The University, Edinburgh
July 1974
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ABSTRACT OF THESIS

Marriage in industrialised, urban society constitutes, it is frequently suggested, a partnership involving expectations of mutual emotional support, the sharing of responsibility for household management and child-rearing, companionship in leisure activities and the equality of husband and wife. In such a marriage the husband-father focusses his interests and activities on the home.

Most explanatory theses see the partnership marriage as an adaptive response to the isolation of the elementary family. It is argued that, given the isolation of the elementary family, couples are deprived of resources external to marriage and therefore turn to each other for assistance, companionship and emotional sustenance. Thus the marital partnership facilitates family functioning and protects the individual from anomie in a society in which Gesellschaftliche relationships predominate.

However, the husband-father is also the chief breadwinner for the family, and is therefore committed to 'success' in the occupational system. Occupational sociologists suggest that in the professions and higher managerial occupations the achievement of success demands the expenditure of time and effort. But more than this, the husband-father in professional and higher managerial occupations is enveloped within a highly developed occupational culture in which work is defined as intrinsically rewarding and in which a high value is placed on devotion to the task. Such an orientation to work is demanding of time and energy, of a personal investment in the social relationships of work, of identification with the occupational role.
This suggests that for the upper middle-class male, work and family are potentially in competition with each other for his ego-involvement, his time and energy. If this is so, husbands are faced with the problem of integrating their occupational and familial roles and wives with the problem of accommodating both their own role performance and their expectations of their husbands' role performance to the intrusion of work.

Moreover, the upper middle classes are particularly exposed to geographical and social mobility. The family is therefore likely to be faced with those problems consequent on isolation which are usually resolved by a family-centred marital partnership. Further, these families are, given the hierarchical nature of large-scale organisations, denied the richest fruits of the occupation system during the family-building phase of the life-cycle when consumption demands are at their height - when, in effect, the family would most benefit from the rewards of the occupation system.

It is this potential for conflict that I set out to examine by exploring the impact of the occupational role on family roles in hospital medicine and in general dental practice during the family-building stage of the life-cycle. Hospital medicine was selected for study as an occupational group in which, prima facie, the potential for conflict between work and family seemed likely to be high. General dental practice was studied as providing a foil to hospital medicine, that is as an occupational group in which the conflict between work and family seemed likely to be low.
My data shows that participation in family activity is considerably lower among hospital doctors than among general dental practitioners. Lowered participation in family activity affects particularly the sharing of home leisure and may lead to a weakening of the emotional bond between husband and wife.

Secondly, my data suggests that mobility is high among hospital doctors but not among general dental practitioners. The wives of hospital doctors are thus placed in a situation in which they are deprived of the assistance with child-care and household management and of the companionship which stable kin and friendship networks might provide at the same time that they are denied their husbands’ help and companionship by virtue of his heavy workloads.

Thirdly, my data shows that in hospital medicine heavy workloads and high rates of geographical mobility are attended by low and insecure income during the family-building stage of the life-cycle as the richest rewards of the occupational role become available only during the dispersal stage of the family life-cycle. This is not so in general dental practice. As a result hospital doctors find it more difficult than general dental practitioners to maintain the style of life they consider appropriate to their status.

Fourthly, my data suggests that, although the participation of hospital doctors in family activity is limited, their marriages nevertheless constitute a partnership – a partnership that revolves around the joint endeavours of husband and wife to achieve career aspirations. In this partnership the wife’s role is defined as involving support for career goals through the organisation of family
life around the exigencies of work. It is a work-centred rather than a family-centred partnership. It is legitimised by a belief in the importance of the achievement of self-fulfilment in work to a man's happiness and thus to family happiness.

Fifthly, my data suggests that the differences between hospital doctors and general dental practitioners in their marital relationship are related only in part to differences in their occupational situation. It is true that in hospital medicine, but not in general dental practice, career contingencies bring heavy workloads, high geographical mobility and low earning power during the early phase of the family life-cycle. However, hospital doctors find themselves in a particular career situation by virtue of the career decisions they make, and career decisions are made in the light of the orientation they bring to work - an orientation in which intrinsic satisfactions are defined as all important. Given this orientation to work, career paths may be embarked upon regardless of the implications for family life, and spouses may be chosen with a view to their suitability for the role they are expected to play.

Finally, my data suggests that, notwithstanding the legitimation of career contingencies and aspirations, the situationally-structured conflicts which exist between work and family in hospital medicine may be experienced as distressing on the personality level by wives. Where this is so there may be marital tension. It seems that the distress that is experienced by wives is a function of both the objective intensity of the problems experienced and the values and expectations which wives bring to marriage. Hospital doctors and their wives - like general dental practitioners and their wives - attach considerable importance to the involvement of fathers in child-rearing, to
companionship in leisure activities and to the giving and receiving of sympathy in marriage. In effect they subscribe to incompatible value systems.

This clash of aspirations may also help to explain attempts by junior hospital doctors to modify their occupational situation. Collective action (through, for example, the Junior Hospital Doctors Association) represents an attempt by hospital doctors to change their occupational situation so that they may practice the kind of medicine they find satisfying (rather than enter general practice which they believe will not be intrinsically rewarding but which, like general dental practice, is more compatible with the realisation of a family-centred marital partnership) in a career situation which will leave them free for familial involvement and provide them with the means of maintaining the life-style they believe to be appropriate to their status.

These findings have revealed fundamental conflicts between work and family life and thereby call in question structural-functionalist conceptions of a 'fit' between modern occupational systems and the conjugal family system. They suggest that the impingement of work on family life may result in a situation in which the family is not adequately performing the functions commonly ascribed to it in the literature; in particular, wives are inadequately protected against anomie.

This study of the marriages of hospital doctors and their wives and of general dental practitioners and their wives is a case study of the way in which the marital partnership may be shaped by a particular set of occupational circumstances and values. However, my findings should be generalisable to other occupational groups in similar situations and with similar values.
Marriage in modern Western societies is, it is frequently suggested in the literature, based on sentiment and notions of romantic love, involving an affinity between individuals and expectations of happiness and personality fulfilment.¹ "No longer," says Kephart, "do we think of marriage in terms of duty and privileges, institutionalised procedures, or rights and responsibilities of husband and wife. Increasingly, marriage is conceived of in terms of personality fulfilment, the satisfaction of emotional needs, and the attainment of overall happiness."² In similar vein, Goode writes of the family as the main place in which the 'emotional input-output balance' of the individual husband and wife is maintained, in which 'their psychic wounds can be salved or healed'.³

Most writers see this conception of marriage as entailing the expectation that the marital relationship will constitute 'a partnership' revolving around the needs and interests of husband and wife, parents and children. 'This conception,' says Kirkpatrick, 'is indeed tinged with romanticism but the thought is of a serious commitment which involves comradeship in love, work, play, parenthood and vicissitudes of fortune.'⁴ Similarly Burgess et al, in a now classic statement, claim that the companionship family, characterised by the mutual affection, sympathetic understanding and comradeship of its members, is emerging as the dominant family type in industrial societies.⁵

This marital partnership is variously described by family theorists and researchers as involving:

(1)
1. mutual affection and the sharing of emotional concerns; 
2. the sharing of child-rearing and domestic activities; 
3. companionship in leisure activities and shared friendships; 
4. the equality of husband and wife with consensus in decision-making.

Embodied in this analysis of modern marriage is the suggestion that the husband-father role is no longer confined to breadwinning but has been enlarged to include active participation in family life. The husband-father, it is being suggested, is expected to participate in household tasks and child-rearing, to share with his wife leisure activities and friendships, to be a 'pal' to his children and a 'friend' to his wife, sharing with her deeply emotional concerns. He is expected to integrate the family into his life-plans, to see himself as a family man, and to find his major satisfactions in family life.

Such a definition of the husband-father role implies the investment of time and energy in family life, and the definition of family activity as intrinsically meaningful activity, as a 'central life interest'.

Explanation of the importance of the partnership marriage

Most explanatory theses see the 'marital partnership' as an adaptive response to a situation in which the isolation of the elementary family deprives husband and wife of resources external to the marriage and thus obliges them to turn to each other for assistance, companionship and emotional sustenance. The isolation of the nuclear family is in turn seen as a response to changes in the occupational system. This thesis was first clearly enunciated by Talcott Parsons.
Parsons' approach to the marital relationship has as its starting point the notion that, in a differentiated and specialised occupational system, the organisation of occupational roles about standards of effectiveness and competence necessitates the institutionalisation of universalistic and achievement criteria. This leads to a weakening of kin ties in that (a) the particularistic and ascriptive claims of kin are set aside in the playing out of occupational roles and (b) geographical and social mobility (which disperses kin) are generated by the need to ensure that occupational positions are filled by those best fitted to hold them. These conditions, it is suggested, impinge most forcefully on the urban middle classes. 13

Given the isolation of the nuclear family, spouses are, Parsons argues, in a 'structurally unsupported' situation. So, neither party has any other adult kin on whom they have a right to 'lean for support'. Husband and wife are thus thrown upon each other. Marriage comes to be based on love and functions as the major source of emotional stability for the adult.

Parsons sees this type of family system as 'fitting' the occupational system on two counts. Firstly, the weakening of kinship ties leaves family members free to compete in the occupational system unhindered by particularistic family ties and obligations. Secondly, the conflict that might arise if family members were to play roles opposite each other in the occupational system is avoided. The possibility of conflict arises since roles in the economic system are functionally specific and governed by achievement and universalistic values, while roles in the family system are diffuse and governed by ascriptive and particularistic values. Thus, if family members were
to hold roles opposite each other in the economic system, they would be required to act out contradictory values at the same time.

This thesis has gained wide currency. It is advanced, with varying degrees of sophistication by Linton, Blood and Wolfe, Goode and Burgess et al. among others. In Britain, a variant of the thesis has been used to explain the home-centredness and jointness of conjugal relationships which are said to characterise family life on municipal housing estates. Willmott and Young, Mogey and others suggest that the working classes are exposed to geographical mobility, but they see this mobility as occasioned by re-housing policies shaped by a political ideology aimed at the redistribution of wealth and the provision of 'decent' housing for all. They suggest that, when the family is moved to a housing estate, physical distance breaks up the male peer group and constrains relationships with kin. Because of the normative uncertainty of their situation and/or because of lack of the skills in establishing new relationships, neither traditional patterns of neighbouring nor friendship cliques emerge. In the absence of external contacts of any kind, the home becomes the focus of a man's life and marital partnership emerges.

The isolation of the nuclear family/marital partnership thesis finds its fullest elaboration in the work of Elizabeth Bott. More carefully than Parsons et al, she outlines the mechanisms producing an association between the external relationships of the elementary family and the patterning of marital roles. Where, Bott suggests, social networks are close-knit (that is where there are many relationships between the component parts), then members of the network tend to reach consensus on norms, to exert informal pressure on one another
to conform to norms and to keep in touch with one another. Thus, if both husband and wife come to marriage with such close-knit networks, they tend to be drawn into activities with people outside the marriage. Emotional satisfaction, companionship and material aid may be found in these relationships and, consequently, conjugal roles tend to be 'segregated'.

But where networks are loose-knit (that is where there are few relationships between the component parts of the network), then there is likely to be variation in norms, social control and mutual assistance are likely to be more fragmented, less consistent. Thus, if husband and wife come to marriage with loose-knit networks, or if conditions are such that their networks become loose-knit after marriage, then they must seek in each other the emotional satisfaction, companionship and help with familial tasks that couples in close-knit networks get from outsiders. Consequently, the conjugal relationship becomes a 'joint' relationship. 21

She then goes on to argue that variations in the connectedness of urban networks are determined by (1) social and geographical mobility, (2) neighbourhood homogeneity-heterogeneity, (3) opportunities for making relationships outside the neighbourhood and (4) the presence/absence of links between the economic system and the family system.

Bott's approach thus differs from that of Parsons et al in that: (a) she does not seem to see our society as uniformly subjected to social and geographical mobility and the absence of links between the economic system and the family system, (b) given this, she does not see the external relationships of family members as necessarily, or even predominantly, tenuous, 22 and (c) she suggests that 'segregated' as
well as 'joint' conjugal relationships may be found in an urban environment. But, like Parsons et al, Bott believes that marital roles are shaped by the external relationships of the family, and, like them, she sees social and geographical mobility and the nature of the links between the economic system and the family system as important factors in determining the pattern of social relationships within which the elementary family has its being. And Goode feels that this emphasis on emotionality serves also as a salve for the psychic wounds received in a competitive and individualistic occupational system. Further, Bott's exposition, though not explicitly functionalist, also contains the notion of a 'fit' between network connectedness and the segregation of conjugal roles. A joint conjugal relationship is, she says, necessary to family functioning and the psychological well-being of the individual where networks are loose-knit: couples must help one another in carrying out family tasks, share each others' interests, get on well together for there is no sure or continuing external source of material or emotional support. In effect, like Parsons et al, she sees the marital relationship as protecting the individual from anomie in a society dominated by gessalschaftliche relationships.

In sum, the elementary family unit is very generally seen as living out its life in situations in which social relationships are tenuous. Given this, close marital and parent-child relationships function to meet the need for primary relationships once provided by the local community and/or kinship group. Marriage is, it is said, the only long-lasting relationship most adults experience, their major source of companionship and emotional gratifications. In marriage and family life they are protected against anomie. Further, says Goode, this emphasis on emotionality serves as a salve for psychic wounds received in a competitive and individualistic occupational system.
The role of ideology in conjugal relationships

I have dealt at length with structural-functional theses suggesting a relationship between the isolation of the elementary family on the one hand, and the structuring of conjugal relationships on the other hand, since this thesis dominates the literature. However, it is also sometimes argued that conjugal and parental roles have an independent source in 'ideational currents': in contemporary conceptions of the essential nature of man and woman and of the sexual relationship deriving, partly, from the individualistic ethos of modern Western civilisation and, partly, from a belief in the importance of warm personal relationships consequent on the development of psychoanalytic and psychological theories of personality growth.

The importance of the ethos of individualism in shaping family roles is admitted by Goode. He argues that an individualistic and democratic ethos runs through the conjugal family system, giving rise to the emancipation of women and undermining sex-based definitions of conjugal roles and the old patriarchal ideology. Goode sees this ideology as growing from that set of more general radical principles proclaiming the equality of the individual as against class, caste or sex barriers that is rooted, ultimately, in ascetic protestantism.

He writes:

'The part which ascetic Protestantism played in the development of science, industry, and capitalism has been amply documented. Its impact on a developing philosophy of antitradditionism, freedom of speech, equalitarianism, political liberty, and individualism was less direct but perhaps no less weighty. Its contribution to the gradual transformation of that philosophy into an ideology of the conjugal family seems equally important, but historical enquiry has not yet turned its attention to those connections. It is at least suggestive that serious debates about laissez-faire economics, political liberty, industrialisation,
and the new family system all had their roots in that same individualistic philosophy, rooted ultimately in Protestantism, and that these debates began to take place toward the end of the eighteenth century.  

Goode suggests that this democratic ideology enters a society through some spokesman before the material conditions for the existence of the conjugal family are present and prepares the members of that society for adjustment to changing structural conditions.

The power of ideology in shaping marital patterns is also admitted by Young and Willmott in 'The Symmetrical Family'. ‘Feminism’, they say, was in the long run an influence almost as decisive as structural factors in shaping the growth of symmetry inside the family. And they see 'feminism' as nourished by individualism and the democratic insistence on the spiritual worth of the humblest. They write:

Once it began to be denied that power should be ascribed to rulers solely by their birth into the station of life of a particular family, once elementary democratic rights had been granted to men, or some of them, once slavery had been abolished, once the claims of the new individualism had been acknowledged for men, the same arguments could be used against men by champions of people born into a particular sex and so condemned, by their chromosomes alone, to inferiority in society. 

Insistence on the equality of women with men, they suggest, helped to fashion the desegregation of roles within the family and the concept of partnership in marriage. 

While the ideology of democratic individualism may have helped to shape the marital partnership by its emphasis on the equality and rights of women, psychotherapeutic ideology may have done so by its emphasis on the importance of parental love, of sexual fulfilment and of emotional security. In essentials, psychotherapeutic ideologies advocate concern, sympathy, even affection in human relationships,
and seem to have gone some way to creating a generalised concern with the quality of human relationships, a concern from which familial relationships will have benefitted. But more than this, psychotherapeutic ideology, by its emphasis on the importance of socialisation within the family to personality development, elevates the family as a system of affective relationships to a supreme position in social life.  

This familialistic cult emphasises the importance of parental (paternal as well as maternal) love and emotional security in child-rearing and, it is suggested by Shaw and Young and Willmott among others, has shaped the child-centredness of the modern conjugal family.  

Psychotherapeutic ideologies emphasise the importance not only of parent-child relationships but also of the marital relationship as 'alone offering the adult in our society a relationship in which he can be accepted as a whole person', as marking 'the final stage in their own evolution towards social maturity'. These theories may have helped to create an awareness of the love and security needs of the marital partner and a new understanding of the sexual relationship. The Pahls say of this concern with the style of personal relationships:

...many young people today, particularly those at university, appear to be obsessed about the quality and style of personal relationships. The subtleties and nuances of behaviour are understood with probably greater perceptiveness than their parents ever had. The 'feminisation' of young men may have helped to make many more young men sensitive to the feelings of the young women they know or live with.  

Although theorising on the impact of ideological factors on conjugal roles is slender, it seems to me that any adequate
explanation of marital role patterns must take account of both ideational and situational factors. For, as Weber so forcefully argued long ago, action is determined not only by conditions but also by ideas. It may be that the marital partnership is readily adopted as a solution to the problems posed by the isolation of the elementary family because it 'fits' contemporary conceptions of the nature of man-woman relationships. That is, those couples most susceptible to a body of psychological knowledge which suggests mutuality of consideration in man-woman relationships (and therefore in marriage) and/or to an individualistic ethic which suggests de-segregation of sex roles, may be those couples for whom the traditional pattern of marital behaviour is becoming problematic by virtue of the situation in which they find themselves. Moreover, the 'looseness' of network structures may help to create structural conditions favourable to the dissemination of new ideas and values. For close-knit networks tend to perpetuate traditional values and patterns of behaviour, while loose-knit networks may facilitate the adoption of new values and norms by breaking up reference groups and weakening social controls.

A Problem

To sum up, the literature suggests that:

1. Family Life in modern western industrial societies is based upon the expectation that marriage will constitute a partnership. This expectation implies that the husband-father will not only be the family breadwinner but will also be actively involved in child-rearing and household management, participate in leisure activities with his wife and children and give and receive emotional support. Further, the husband-father role is expected to be an important part of his self-image and family life is expected to be a major source of gratifications.
2. Definitions of the marital relationship as 'a partnership' may derive from 'ideational currents' emphasizing the equality of women, the importance of emotional security and well-being in interpersonal relationships, and of love in sexual relationships.

3. At the same time, the marital partnership represents a solution to the isolation of the elementary family consequent upon occupation-system generated geographical and social mobility. A husband's involvement in household tasks and child-rearing facilitates family functioning, and the companionship and emotional security husband and wife derive from each other (and from their relationships with their children) protect them against anomie.

4. This family system 'fits' the occupational system in that:
   (a) the social and geographical mobility necessary to job placement are facilitated
   (b) possible conflict between the different expectations and norms of family and workplace are avoided
   (c) the emotionality of the conjugal family heals the wounds sustained in an individualistic occupational system.

Now analyses of family values and role relationships that proceed in this vein ignore the husband's occupational role. This is curious for it is, on the face of it, likely that occupational aspirations and the situational context within which occupational roles are performed will have implications for involvement in family life. And in fact the husband-father is unlikely to be readily available to his wife for assistance, companionship and emotional support in those occupations - usually professional and higher managerial occupations - in which work plays an important part in the life-organisation of the individual: in providing him with an identity, shaping his social relationships in and out of the workplace, absorbing his time, his energies and his interests.
and giving him life-satisfactions. There would thus seem to be some incompatibility between upper middle-class occupational roles and the husband-father role. Moreover, this incompatibility may not easily be resolved by a lowering of occupational aspirations and a reduction in the amount of time and energy spent in work since the maintenance of the family's status and consumption patterns may be dependent on the realisation of occupational aspirations. Indeed commitment to the economic rewards of work may increase on marriage.

This is a problem that needs investigation. There is a sociological problem in that (a) the inter-relationship between the occupational role of the husband-father and his familial roles needs to be examined, and (b) questions are raised concerning the 'fit' between the occupational system and the family system. There is a social problem in that structured incompatibilities between family and occupational situations and values may lead to marital tensions and breakdown.

British community studies provide evidence which is suggestive of this problem in that participation by the husband-father in familial activities is shown to be greater in the working classes than in the middle classes, though this is the group in which we might, on the basis of family theorising, expect the husband-father to be the more involved in family activities.

Studies of working-class family life suggest that most husbands participate in domestic tasks and child care, doing not only much of the heavy work but also helping in traditional women's tasks, washing and drying dishes, helping with the shopping and making tea.
Responsibility for family planning and child-rearing is shared. Leisure is home-centred. Husbands watch television with their wives and kids, instead of drinking beer in the pub with their mates. At weekends they tend their gardens or take the family out.

This marital partnership has been observed not only among the 'privatised' and affluent working classes living on housing estates and in areas characterised by population heterogeneity, but also among younger couples in traditional working-class areas characterised by close-knit social networks and communal solidarity. This pattern is attributed by Shaw and by Young and Willmott to the influence of popular psychology and is seen by them as evidence of generalised cultural expectations of partnership in marriage. Correlatively, this evidence suggests that 'jointness' in the conjugal relationship is not a simple function of the connectedness of the network structure in which the family has its being.

By contrast, husband-father participation in familial activity seems to be limited in certain sections of the middle classes. For example, Willmott and Young find that, although most men in suburban and predominantly lower middle-class Woodford participate in the work of the home, the young executive constitutes a new sort of absentee husband - a husband who spends nearly all his time out of the home making money and who gives his wife little help in the home. Gavron's data points in the same direction. She shows that the proportion of middle-class wives in her sample not receiving help from their husbands with child care and domestic tasks is greater than in the working classes.
Where the sharing of leisure activities is concerned, Willmott and Young suggest that the young executive spends his leisure with business colleagues, leading a life that is so different from his wife's that 'they hardly seem to inhabit the same world'. Gavron points out that, while leisure activities in the working classes are home-centred, leisure in the middle classes revolves around entertaining friends and going out. Much of this activity is shared. Thus 79% of her middle-class couples reported going out together regularly once a week compared with only 27% of the working-class wives. But at the same time the proportion of husbands who sometimes go out without their wives is greater in the middle class than in the working class (48% compared with 27%).

Assessing the significance of this empirical evidence is fraught with difficulty since various methodological problems are involved in the conceptualisation and operationalisation of the marital partnership. Sharing/not sharing in those areas of activities normally taken as indicators of a marital partnership - domestic chores, child care, leisure, decision-making - may or may not coincide. This has been noted in several empirical studies, but the implication for the marital partnership concept has not been resolved. It may be, as Komarovsky has pointed out, that what specifically is shared is more important for the feeling of psychological intimacy in the relationship than how much of one's life is shared. Further, some areas of activity may be more important than others for the relationship as a whole. For example, the sharing of leisure activities may be more important for the psychological intimacy of the relationship between husband and wife than, say, the husband's participation in household tasks. But we cannot know this
unless the meaning of various familial activities for the actors concerned is examined and this is not usually done. A related problem is that most studies of marriage examine marital role behaviour, not marital role expectations. Consequently, we know something of the sharing of activities between husbands and wives, but little or nothing of their expectations of each other or of the meaning of particular activities, shared or separate, to them.

But whatever the methodological problems involved in interpreting the results of empirical investigations, we are presented with the paradox that the husband-father's participation in family activities seems to be more limited in professional and higher managerial families than in lower middle-class and privatised working-class families: that is, familial participation is more limited in those groups subject to the greatest geographical mobility and among whom we can expect to find the socially-mobile of lower middle-class, if not skilled manual, origins. But, according to accepted sociological dogma, these people are living out their lives in a situation in which resources external to their marriage are unavailable to them, and they should therefore be forced into a partnership marriage. Further, according to accepted dogma, professional and managerial groups are the groups most exposed to competition and consequent psychological burdens in their work roles, and so should need to find emotional sustenance in a close marital relationship. Moreover, men and women in these groups are, it is suggested, likely to be particularly sensitive to 'ideational currents' by virtue both of their exposure to university education and of the looseness of their networks. It is this paradox that I have explored by examining the impact of the occupational role on familial roles in two middle-class occupational groups: junior hospital doctors and general dental practitioners.
Before proceeding to outline the way in which I approached the exploration of this problem, I turn to an examination of the sociological literature on occupational roles in order to show that there is evidence for my contention that in professional and higher managerial groups the occupational situations and values are such that:

1. the occupational role may be so demanding of time and energy that there may be problems in the allocation of time between work and family;

2. the occupational role may be so important to the worker's self-image and occupational relationships so important a source of emotional gratifications as to be productive of problems in apportioning what the Rapoorts term 'ego-involvement' as between work and family;

3. geographical mobility may be high thus isolating the elementary family.

OCCUPATIONAL ROLES

In examining the potential implications of occupational roles for family life, I look, firstly, at occupational situations and, secondly, at occupational values.

Occupational Situations

Two types of occupational situations are distinguished in the literature: that of the independent professional, entrepreneur or craftsman characterised by few levels of authority and having few employees, and that of large-scale formal organisations with multiple and geographically scattered units, characterised by a hierarchic structure of authority, the progressive specialisation and differentiation
of occupational roles and increasing rationalisation.

Within large-scale organisations, a line is usually drawn between salaried employees who occupy positions which are part of a bureaucratic hierarchy, and those who do not, between, in other words, those with managerial or professional skills (the middle class) and those with manual skills (the working class).

The structure of opportunity pertaining to each occupational situation has implications for the family in terms of:

1. earning power;
2. the allocation of time between work and family;
3. geographical mobility;
4. the formation of social networks.

1. Earning Power

The distinction within large scale organisations between salaried employees who occupy positions which are part of the bureaucratic hierarchy and those who do not delineates two contrasting structures of opportunity.

For those who are part of the bureaucratic hierarchy advancement is by means of a career, that is by promotion up the hierarchy of authority, responsibility and prestige. Such promotion is to be achieved by individual effort and in competition with others. The career has been admirably and succinctly defined, in structural terms, by Wilensky as 'a succession of related jobs arranged in a hierarchy of prestige through which individuals move in an ordered predictable sequence'. Wilensky goes on to argue that, by holding out the prospect of continuous predictable rewards, careers foster a willingness to train and achieve,
to adopt a long time perspective, and defer immediate gratification for the later pay-off. In Mannheim's phrase, they lead to the gradual creation of a 'life plan'.

Income for those in a career structure varies considerably over the life-cycle. The young man with his career in front of him typically begins his working life on a salary that is low in relation to that which he may later earn since his earning power increases as he works his way up the career ladder. Thus his earning power may be low during the home-making and early child-rearing stage of the family life-cycle but high during the dispersal stage. This increase in earning power (paralleling his progress up the career ladder) will be dependent on the expenditure of energy, effort and initiative and the readiness to accept ever increasing responsibility.

The situation of the careerist is in marked contrast with that of workers on the factory floor and, increasingly, in the office, for whom there are few clear cut sequences of progressively more skilled, better paid jobs. Advancement for these workers depends on monetary rewards for their present economic role. This can be achieved, individually, by being geographically mobile - by being prepared to go where the money is - or, collectively, through trade union action. Improvements in earning power obtained in this way do not usually involve increased effort or responsibility. Further, given the absence of a hierarchic structure, the income of these workers is usually spread fairly evenly over the life-cycle. Thus their income, unlike that of the salaried employees of a bureaucratic organisation, may be high (in real terms) during the home-making and child-rearing stages of the family life-cycle compared with what it will be at the end of their working lives (and the dispersal stage of the family life-cycle).
For the independent professional, entrepreneur and craftsmen, as for the manual worker, there is no ladder to climb. For him, as for the manual worker, improved economic standing is dependent on increased monetary rewards for his present economic role. For him, as for the manual worker, earning power may be high at the beginning of his working life compared with what it will be at the end of his working life. However, there is a significant difference between his opportunity position and that of the manual worker in that advancement will depend, not on collectively regulated wage increases for the performance of the same tasks and involving no increased expenditure of effort, but on individual endeavour aimed at the expansion and success of the enterprise.

2. Time

Societal norms appear to define as desirable a working week of no more than 40 hours, running Monday through Friday with each working day ending before 6.00 p.m. This delimitation of the working week segregates work time from family and leisure time and represents an institutional mechanism for the reduction of possible conflict in the allocation of time.

However, 'success' in any opportunity structure may entail working outside the 'standard' working week. In a career structure, promotion, being dependent on individual effort and a willingness to accept ever-increasing responsibility, may entail working long hours. For the independent professional or entrepreneur, expansion of the enterprise may involve long hours of work. The manual worker may seek to improve his economic standing by overtime and shift work or by moonlighting.
By contrast, the office worker who is given little opportunity for paid overtime work and who has little prospect of career climb may rarely work outside the 'standard' working week.

Hours of work studies provide evidence of the importance of 'overtime' work to the economic standing of manual workers and senior management and professional people. For instance, a report by the National Board for Prices and Incomes showed the average working week of men in manual work to be 46½ hours, an average of at least 3½ hours a week more than that of white-collar employees. Similarly, Young and Willmott found that the average weekly working hours (including time spent on a second job and working at home) of professional and managerial men was 50⅓/10th hours, of clerical workers 45⅝/10th hours, of skilled manual workers 48⅔/10th hours and of semi-skilled and unskilled workers 47⅔/10th hours. Various accounts of the working hours of managers suggest that managers tend to work over 40 hours a week and that the more senior the manager the longer the working week. Burns' managers worked an average of 41⅔ hours, Horne and Lupton's 44 hours, Rosemary Stewart's directors 42½, while Kerrett's directors averaged 53 hours, Copeman's managing directors 49½ and Young and Willmott's managing directors 48½.

Work outside the 'standard' working week may be demanded by the exigencies of particular occupational situations rather than its opportunity structure. Thus in occupations where a 24-hour service is required, as in hospital medicine, flying, or the police force, men may be required to work 'unsocial' hours. Again, in some occupations absence from home may be required - as in deep sea fishing, journalism and lorry-driving.
Thus, opportunity structures or specific occupational situations may result in working outside the 'standard' working week and so create difficulties in the allocation of time between work and family.

3. Geographical Mobility

Careers in hierarchic organisations generally entail geographical mobility since promotion may be dependent on transfers within the organisation or on movement between organisations. This type of career advance, for which Watson coined the term 'spiralism', has been shown to be an important by-product of bureaucratisation.

Bell, for example, examining the relationship between occupational situation and geographical mobility finds that an individual's mobility is related to the size and number of branches of the firm for which he works. Willmott and Young found that husbands and wives in their middle-class sample in suburban Woodford take geographical mobility for granted. Similarly Whyte's organisation men expect to move from community to community as their corporations change their assignments; and for Seeley, Sim and Loosley's transient Crestwood Height dweller 'a prime requisite of their career is a seemingly effortless mobility, personal movement in physical and social space'.

Here, again, the occupational situation of the 'careerist' is in marked contrast with that of both the independent professional and entrepreneur and the manual worker. Independent professionals, entrepreneurs and craftsmen are tied economically and socially to a particular locality by the nature of their business - by the fact that their success is dependent on building up a local reputation and clientele. Watson calls such locally-oriented people 'burgesses'.
Manual workers, on the other hand, may improve their economic position by moving to those areas in which wages are high. This course of action may be adopted by workers in declining areas.\footnote{31} But for workers in prosperous industries, geographical mobility is obviously pointless, and the mobility of manual workers is generally lower than that of middle-class workers.\footnote{32}

In sum, where the husband-father is in a career situation, families are likely to be geographically mobile, but where the husband-father is an independent professional or manual worker, families are likely to be geographically stable.

4. **Networks**

Middle-class occupations, Wilensky suggests, necessitate sustained and wide ranging contact with colleagues and superiors within the firm and with clients and customers without the firm. Consequently, the social relationships of work may be carried over into non-working life, and there may be much mixing of business with pleasure.\footnote{33}

However, a distinction must be made between the social networks of the spiralist and the burgess. The spiralist cultivates the friendship of fellow-workers and superiors. His future is in the company for which he works and it is to the company and the social relationships of the company that he is tied both economically and socially.\footnote{34}

The burgess cultivates the friendship of prospective clients and customers in the locality. He does so by joining clubs and associations, by being careful to be seen at the right local functions and to meet the right people. His future is in the locality and the opportunities which
lie in the locality, and therefore it is to the locality and the social relationships of the locality that he is tied both socially and economically.\textsuperscript{85}

By contrast, the occupational situation of the manual worker and office worker is such as to isolate them from fellow workers by virtue of the constraints of technology or office layout, and to make unnecessary customer or client contact. In such circumstances, the social relationships of work are unlikely to be carried over into leisure activities. Work and leisure are sharply split, ties to the community are uncertain.\textsuperscript{86}

Thus, both the spiralist and the burgess husband-father is more likely than the working class husband-father to be involved in work-related social activities and relationships outside the workplace.\textsuperscript{87}

To summarise, conditions of work for middle-class males in large-scale organisations mean that:

1. the family is exposed to geographical mobility which, by loosening kinship and neighbourhood ties, isolates the elementary family thereby making husbands and wives dependent on each other for assistance, companionship and emotional support;
2. the husband-father’s participation in family life may in fact be limited by the 'overtime' work which may be necessary to career climb;
3. the cultivation of 'friendship' relationships among fellow workers and supervisors may offset for husbands (but not for wives) the isolating effects of geographical mobility;
4. at the same time, earning power in the home-making and family-building stage of the life-cycle (when family consumption demands are at their peak) is relatively low; the richest fruits of the
occupational system may not be reaped until the dispersal stage of the family life-cycle.

In contrast, conditions of work for the working class male and for the independent professional and entrepreneur may entail overtime work, but do not entail either geographical mobility or a disjunction between the patterning of family consumption demands and of occupational rewards.

**Occupational orientations**

But while the situation in which the 'careerist' finds himself may have the implications just outlined for family life, no set of structural conditions can, by itself, have strong determinative effects. Much must depend on the personal plans and orientations a worker brings to his work situation.33 Thus the extent of geographical mobility, of cultivation of the social relationships of the work place and of 'overtime' working in the life history of an individual may be determined not only by his conditions of work but also by the meaning he attaches to work - by the place which work occupies in his life-plans and by his definition of work as intrinsically or extrinsically rewarding.

Now, the literature on occupational values suggests that in our society workers in professional and higher managerial occupations are exposed to two sets of influences which tend to make work, in Orzack's phrase, 'a focal centre of self-identification, both important and valued'.39 Given this, the tendencies inherent in their occupational situation may be reinforced.

Generalised cultural expectations of occupational 'success' represent the first of these two sets of influences. In our society occupational
position is a major factor in the achievement and validation of social status. Consequently, the adult male is expected to be successful at his chosen occupation and, by achieving success, to maintain or achieve status in the community. In the middle classes, status aspirations are particularly well defined and the grooming of the young child for his future occupational role is thorough - as the work that has been done on the educational advantages enjoyed by the middle-class child demonstrates. Thus in the middle classes, status aspirations breed hopes of occupational success and reinforce both the tendency to career climb inherent in large-scale organisations and the tendency to expansion of the enterprise inherent in the situation of the independent professional.

Secondly, the adult male in our society is exposed to the expectations of the occupational group of which he is a member. The expectations of occupational groups vary considerably in the degree to which they are articulated and in their content. But, it is suggested, the more professionalised an occupation, the more highly developed and clearly articulated its norms and values, the greater the part it plays in the life-organisation of the individual. It is further suggested that within a highly developed and articulated occupational culture work tends to be defined as a 'central life interest', as intrinsically meaningful.

This attitude toward work is said to lie at the very heart of the professional ethic. Professional work, says Greenwood, 'is never viewed solely as a means to an end; it is the end itself. Curing the ill, educating the young, advancing science are values in themselves.'
Absorption in work, Greenwood continues, is 'not partial, but complete; it results in a total personal involvement.... to the professional his work becomes his life'. Hence, in Greenwood's view, the act of embarking on a professional career is similar in some respects to entering a religious order.

While the professions may require the strongest commitment of their members, other high status occupations also require positive involvement of the worker. The extent to which devotion to work is culturally expected of those in middle-class occupational positions, and the way in which those in middle-class positions are socialised into this expectation, is indicated by the objectives of management education as enumerated by the British Institute of Management. This august body believes that work ought to be a 'central life interest'. The ideal manager is, in their view, 'deeply committed', 'loyal', and 'ambitious'. Consequently the objectives of management education programmes ought to be to ensure that all managers reach their own personal summit. This may mean that some managers need 'indoctrination', or a 'change of attitude', some need a 'jolt' and others need to be made artificially mobile by rotation.

The definition of work as intrinsically rewarding among professional and higher managerial groups carries with it important implications for behaviour in and out of the workplace.

In the first place, the pursuit of monetary rewards is by definition subordinated to the quest for 'psychic satisfactions' to be derived from work itself. This means that monetary motives feature only minimally in career decisions and in the performance of the occupational role.
Secondly, an intrinsic orientation to work implies a concern for high performance standards, sensitivity to the demands, expectations and rewards of the organisation, and devotion to the task. Hard work is believed to be a virtue. This concern for high performance standards is demanding of time and energy, and is conducive to an attitude in which the working day is seen as coming to an end when the job in hand is completed, not at an institutionalised 'clocking out' time. 'The work life', says Greenwood, 'invades the after-work life, and the sharp demarcation between the work hours and the leisure hours disappears.'

Thirdly, the intrinsically-oriented worker regards work as a milieu appropriate to the development of highly rewarding primary relationships, that is as a milieu in which expressive and affective needs will be met. Thus workers identify with fellow-workers and the social relationships of work are likely to be carried over into non-working life. Occupational communities may develop and feelings of fraternity and comradeship may be expressed through a distinctive occupational culture.

The depth of identification with colleagues has frequently been cited as a distinguishing characteristic of the professions. The professionalisation of an occupation, it is argued, generates its own sub-culture, sustained by elaborate formal and informal arrangements, a code of ethics and a professional association. Thus members of the professional colleague group have a common understanding of each other, share a common tradition, and come to constitute, in Caplow's terms, 'a fairly tight knit enclosure', in Hughes' terms a 'moral unit'. All this means that the colleague group is for the professional his reference group. And, further, that commitment to the group is deep.
In Hughes' view, commitment to the colleague group may be likened to commitment to a family. He says, describing the way in which the medical profession cherishes its recruits, 'the theme is mutual commitment, reinforced by students' auxiliaries sponsored by the professional associations, and by the use of such terms as 'student-physician', which stress that the student is already in the professional family. One owes allegiance for life to a family.

Finally, for workers who see work as intrinsically rewarding, work and success at work is an important element in their self-image, a major source of their sense of self-worth. It is because the definition of work as self-expression is central to the ethos of the professional that the term 'profession' has come to be 'a symbol for a desired conception of one's work and hence, of one's self'. And because work is an important element in the self-image of the professional, the occupational role is elaborated beyond the workplace door into a life-plan. Occupational identity is used as a status-winning device, work is fused with leisure, work relationships with non-work relationships, the obligations and privileges of the occupational role become all-pervasive.

The foregoing discussion of the orientations which the middle classes are said to bring to work suggests that the tendencies inherent in their occupational situation are in fact reinforced by the meanings they attach to work in that their commitment to success coupled with their definition of work as the area of life in which self-fulfilment is to be achieved tends to:

1. a commitment to high performance standards that is demanding of time and energy;
2. a commitment to geographical mobility;
3. the development of highly rewarding primary relationships in the workplace;

4. identification with the work role.

This discussion of the orientations to work attributed to middle-class men in the literature suggests that they are both committed to 'success' (to reaping instrumental rewards from work) and to a search for intrinsic satisfactions in work. They may, the literature suggests, be encapsulated within occupational cultures in which work is defined as intrinsically rewarding. But they are also exposed to generalised cultural expectations of 'success', and the maintenance of a middle-class life-style is dependent on the achievement of success. Further, when doing my pilot study I was repeatedly struck by the fact that many of my respondents seemed to be concerned to maximise in work both intrinsic satisfactions and extrinsic rewards. A paradox?

I am not sure that at the middle-class level the distinction commonly drawn between intrinsic and extrinsic orientations to work is useful since there is - in the achievement of success considerable personal satisfaction. The high-flier may set out to achieve monetary rewards, status and social prestige but in the middle class occupational world the achievement of these rewards is the result of individual achievement - of high performance standards on the job, of pitting your wits against others and winning - and in personal achievement self-fulfilment is experienced. Thus for many middle-class men money and social prestige are valued not only as the wherewithal to the style of life they desire in the community but as the symbols of personal achievement. Moreover, both the desire for success and the desire for self-fulfilment in work tend to devotion to the task and to identification with the work role.
Even so, as I was to discover, some men may find that their economic aspirations clash with their desire for intrinsically rewarding work in that both sets of aspirations cannot be realised along a particular career path. And insofar as breadwinning goals may sometimes be subordinated to the pursuit of intrinsic rewards, then the family may be denied the richest fruits of the occupational system at the same time that it is denied the husband-father's participation in family activity.

**RESUME: THE CRUX OF THE PROBLEM**

The foregoing discussion has shown that in the view of family sociologists societal values define family living as a distinctive and desired activity, as a 'central life interest'. These values stress the importance of active participation in family activities, a participation which is demanding of time and energy. They stress the importance of the giving and receiving of emotional gratifications within the family, and of close emotional ties between, and identification with, family members. Such values give rise to the image of the 'family man' who integrates the family fully into his life-plans.

But the husband-father is at the same time the chief breadwinner for the family. And in order to perform his income-earning and status-giving functions for the family he is committed to success in the occupational system so that he may achieve for his family the style of life which he, and his wife, presumably desire.

He is committed to success in an occupational system in which, the sociologists of work suggest, success demands the expenditure of time and effort, the cultivation of relationships with colleagues,
clients and customers, and, if he is working in a large-scale organisation, geographical mobility.

But more than this, the husband-father is, in his breadwinning role, exposed to the expectations of the occupational group of which he is a member. Within the highly developed occupational cultures of professional occupations, work is defined as intrinsically rewarding, as the area of life in which self-fulfilment is to be experienced, and a high value is placed on devotion to the task and performance standards. Such an orientation to work is demanding of time and energy, of a personal investment in the social relationships of work, of identification with the occupational role. Further, in the sub-culture of the occupational world, the husband-father has a judging audience in his peer group. Involved in continuous interaction with them, he is under constant pressure to excel.

Personal achievement is, therefore, important to the middle-class husband-father. His status, and that of his family, before the audience of the community depend on his achievement of a high income, of a high prestige occupational position. The esteem with which he is rewarded by his audience in the occupational sphere depends on his ability to do a good job. Both are important to his self-image.

Thus, if we bring together the theses of occupational and family sociologists, we must come to the conclusion that, for the middle-class male, work and family are potentially in competition with each other for his ego-involvement, for his time and energy. If this is so, husbands are faced with the problem of integrating their occupational and familial roles, and wives with the problem of accommodating both
their own role performance and their expectations of their husbands' role performance to the intrusion of work. Moreover, the potential for conflict may be exacerbated where the quest for self-expression in work is given priority over the pursuit of income and status rewards, an ordering of priorities which may deprive the family of the fruits of the occupational system.

It is this area of potential conflict and the mechanisms by which the conflict is resolved that I set out to examine in two occupational groups: junior hospital doctors and general dental practitioners. More specifically, I set out to examine:

1. the 'meanings' that are attached to work and family life and the problems of apportioning 'ego-involvement';

2. the conflict between work and family that may arise from the structuring of income rewards;

3. the conflict between family-system needs for geographical stability and occupation-system needs for geographical mobility;

4. the competition between work and family life for the time of the worker-husband-father.

My research design - and the reason for choosing hospital doctors and general dental practitioners as the subjects of my study - is described in chapter II. In chapter III I examine expectations of work and family life in these two occupational groups. Chapter IV deals with the structure of opportunity pertaining to hospital medicine and general practice and the implications of these structures for family life.
In chapter V, I examine the mobility experience of hospital doctors and general dental practitioners and their families and the implications for family life. Chapter VI deals with workloads and attendant problems. The tension that may exist between the occupational system and the family system as a result of earning power patterns, geographical mobility and heavy workloads is examined in chapter VII. In the concluding chapter, I draw together those findings that relate specifically to the marriage relationship and delineate the way in which this relationship is shaped by the occupational role and the way in which it differs from the marital partnership portrayed in the literature.
CHAPTER II
Research Strategies

THE RESEARCH DESIGN

The problem of investigating the conflict between work and family life was approached by seeking to identify an occupational group bearing middle-class status in which there might be a potential for conflict in that:

a. the occupational role is played out in a situation in which success depends on career climb and in which income on the lower rungs of the career ladder is low in comparison with income on the higher rungs of the career ladder so that the richest fruits of the occupational system are denied the family during the home-making and family-building stage of the life-cycle;

b. geographical mobility is likely to be high;

c. demands on time are likely to be heavy and to extend beyond the 'standard' working week;

d. there is a highly developed occupational sub-culture in which work is likely to be defined as intrinsically rewarding so that the work role tends to be highly valued and the situational constraints of the workplace are likely to be reinforced.

It also seemed desirable to isolate an occupational group bearing middle-class status which would serve as a foil to the first group in that:

a. work takes place in an independent setting in which success depends not on career climb but on expansion of the enterprise and in which income may be high during the home-making and family-building stage of the life-cycle;
b. geographical mobility is likely to be low;

c. demands on time are not likely to be in excess of the 'standard' working week;

d. the occupational orientation is likely to be one in which work is not defined as intrinsically rewarding and the work role is not, in itself, highly valued.

Preliminary investigations\(^1\) suggested that hospital medicine might meet the first set of requirements. In hospital medicine work takes place in an organisational setting in which success depends on career climb involving the achievement of, at the very least, a consultancy. Further, in hospital medicine, incomes are particularly low during the early career stage, tenure of office is limited to short periods of time, and the manpower situation is such that achievement of a consultancy is uncertain.\(^2\) The necessity for career climb, combined with limitations on tenure of office during the early career stages, tends to geographical mobility. Workloads are determined by the need to provide a 24 hour emergency service, a manpower shortage and training (including study) requirements, and are generally said to be heavy. The medical subculture is highly developed and clearly articulated\(^3\) so that hospital doctors are likely to define work as intrinsically meaningful and to identify with their occupational role.

General dental practice seemed likely to meet the second set of requirements. In dentistry income is secure and relatively high in the early career stages. Mobility is likely to be low since success is dependent on building up a local reputation and clientele. The average weekly workload of dentists is known to be within the limits of the standard working week.\(^4\) The dental sub-culture seems to be ill-articulated
and the workplace, by virtue of its isolation, fails to provide meaningful primary relationships, so an important factor in identification with the occupational role is not present.\(^5\)

The selection of two occupational groups in polar situations and likely to have contrasting orientations to work would, it was thought, make it possible to identify and focus attention on sources of conflict between work and family life. So that the effects of the occupational role on marital roles might be more sharply highlighted, it was also decided that the sample should be as homogeneous as possible in all respects. In this way factors extraneous to the problem which might shape marital roles would be eliminated from the study. The following controls were therefore introduced.

Firstly, it was somewhat arbitrarily decided to focus attention on men in the career-building stage of the life-cycle and thus to delimit career contingencies. In the case of hospital doctors, this involved focussing on N.H.S.-employed registrars and senior registrars and university-employed hospital doctors of equivalent status.\(^6\) The post-registration house officer and senior house officer grades were excluded since these grades consist of a large proportion of doctors who are either undecided as to the branch of medicine in which they mean to make their careers or who intend to go into general practice, public health, industry or the services but are first extending their clinical experience by remaining in the hospital service for a few years. They are thus not yet committed to a career in the hospital service. Consultants are, by definition, beyond the career-building stage of the life-cycle.

In dentistry clearly defined career stages are not, of course, to be found. Nevertheless, a distinction may be made between new
graduates without experience, reputation, clientele and financial resources and who may be working as salaried assistants, dentists who are in the process of acquiring experience, reputation, clientele and financial resources, and dentists with long-established reputations and financial security. So as to focus on men who, like the registrar and senior registrar, have 'found their feet' but are in the process of establishing themselves, it was decided to exclude from the sample new graduates and well-established dentists. These considerations implied covering a period of 3-12 years after graduation.

Secondly, it was decided to restrict the study to married men with at least one child. These restrictions were, of course, dictated by the nature of the problem being investigated.

Thirdly, it was decided to sample couples in roughly the same stage of the family life-cycle, that is in the same broad age group and with children in the same age range. This control was introduced since stage in the family life-cycle may be a factor in conjugal role patterns. The family-building stage of the life-cycle - when children are young and men are in their late 20s or early and mid-30s - seemed the most appropriate for study since it is in this stage of the life-cycle that wives face particularly heavy demands in terms of child care and household management and are, by virtue of the demands of child-rearing, particularly likely to be isolated. Further, this stage in the family life-cycle broadly coincides with the career stage chosen for study. Since there are variations in career histories, age controls were formally introduced, and the sample was restricted to men under 38 and with children aged 8 years and under.
Fourthly, it was decided to restrict the sample to men whose wives were not currently in employment. This control was introduced since it has been shown that where wives work, marital roles are affected.

Fifthly, the sample was restricted to men and women married for the first time.

Sixthly, the sample was restricted to men and women of British origin so as to control for national variations in definitions of marital roles.

The restriction of this study to the investigation of the potential for work-family conflict in two professional occupations in itself constitutes a large measure of control for present status levels and for the educational levels of the men.

It was impossible to control for social-class background, a variable likely to have an important effect on orientations to marriage and work. However, the sample proved to be fairly homogeneous in this respect. My respondents came from a wide variety of non-manual backgrounds, but very few came from manual backgrounds. (Table 2:1).

The study was carried out among hospital doctors and general dental practitioners resident in the Edinburgh area. This procedure was based on pragmatic considerations. The research project was being carried out under the aegis of Edinburgh University and I was resident in Edinburgh. At the same time, Edinburgh is a well-established and large medical centre and was thus as well placed as any city outside London to provide a reasonable population of hospital doctors. It also possesses a fairly high ratio of dentists to population and therefore seemed likely to provide an adequate population of dentists.
This study was thus planned as a case study of the potential for work-family conflict and of the marital relationship among men and women in particular occupational groups, at a particular point in the career and family life-cycle, of particular national origins and resident in the Edinburgh area. My findings are an indication of the sources of strain that exist between work and family, of the strategies that may be adopted for mitigating structured strains and of the effect of the occupational role on the familial roles. These findings are doubtless generalisable to other occupational groups and individuals in similar situations and with similar occupational values. Nevertheless, this study is a case study; it is not, and does not purport to be, a general study of the inter-relationship between work and family life in general. It does not do so because 'global' studies of a social class group tend to obscure differences between occupational groups within a stratum and between groups in different stages of the life-cycle. If the crucial links between structures, values and behaviours are to be revealed, case studies of the particular are needed.15

THE SELECTION OF THE SAMPLE

Once the research strategy had been worked out, my next step was to draw up a sample of junior hospital doctors and general dental practitioners to be studied through an interviewing programme. It was intended that the sample should consist of 40 junior hospital doctors and 20 dentists and their wives (a decision which would result in 120 interviews as husbands and wives were to be interviewed separately). This number of doctors and dentists were actually interviewed, but two doctors and four dentists who at the interview proved not to belong to
the desired categories, were excluded from the data analysis. The sample thus effectively consisted of 38 junior hospital doctors and 16 general dental practitioners.

Two considerations influenced the decision to have small samples. Firstly, it would have been difficult to interview a large number of couples in the available time since it was not generally practicable to conduct more than one interview a day. This was so for two reasons: (1) the interviews were long and exhausting and involved considerable travelling time; (2) the interviews usually had to be conducted in the evenings when husbands were not at work and wives were not surrounded by children. Further, it was not practicable to conduct more than four interviews in one week since (a) it was thought undesirable to trespass on weekends for interview purposes unless respondents themselves suggested it; (b) interviewing on five successive nights proved too strenuous; (c) difficulties were sometimes experienced in scheduling interviews.

Secondly, each sample was to be composed of a relatively homogeneous group of men and women and I anticipated being largely concerned with differences between the two samples rather than with differences within each sample. This was so since this was to be a case study of the effect of two different occupational roles on familial roles at a particular point in the life-cycle and an attempt had been made to eliminate variables extraneous to this central problem. Consequently, large samples seemed unnecessary.

Since the total number of couples to be interviewed was to be severely limited, it was decided that the medical sample should
be larger than the dental sample as dentistry was being studied as a foil to hospital medicine. It was in hospital medicine that the occupational role was expected to exercise a shaping influence on the familial role and that conflict between work and family was expected to exist. A larger sample would facilitate the observation of sources of conflict and the strategies by which conflict was resolved.

The selection of the sample was problematic since it was impossible to obtain lists of hospital doctors and general dental practitioners which were limited to the desired categories. A list of registrars and senior registrars in the employment of the N.H.S. was obtained from the South-Eastern Regional Hospital Board, Scotland. The University Calendar provided lists of hospital doctors in university employment and the Dentists' Register for 1969 of all registered dentists. But these lists included the married and unmarried, fathers and non-fathers, men within and without the required age limits, British nationals and non-British nationals. The selection of the sample therefore proceeded in two stages.

In the first stage a random sample was drawn from the lists of all hospital doctors and dentists of the size which preliminary investigations suggested would yield samples of the required size. In the second stage I wrote to these doctors and dentists asking them if they would be willing to be interviewed if they fell into the desired categories and stating that my letter would be followed by a telephone call. They were then telephoned and their status and willingness to be interviewed ascertained. The lists were resampled as necessary.

In the event, 46% of all hospital doctors were approached. Of the doctors approached, 37% said they fell into the desired categories.
Of doctors in the desired categories, 14% refused to be interviewed.

All Edinburgh general dental practitioners in the desired career stages were contacted. Of these, only 32% fell into the desired categories, and of those falling into the desired categories 32% refused to be interviewed. This yielded a sample of only 13 dentists. Consequently, it was decided to extend the area from which the sample was drawn to the immediate environs of Edinburgh. A further eight dentists were contacted, of whom three fell into the desired categories and were interviewed, giving a total sample of 16 dentists.

The characteristics of the samples this selected are shown in Table 2:1.

The number of hospital doctors and dentists studied is small. Nevertheless, they seem to represent nearly all the dentists and a high proportion of hospital doctors working in Edinburgh and falling in the desired categories. Given this, differences between the two groups are unlikely to be the result of sampling error. In other words, observed differences between the Edinburgh hospital doctors and dentists in my study are likely to be 'real' differences.
However, my study is a case study of a particular group of hospital doctors and general dental practitioners. While my findings should, logically, be generalisable to other groups of hospital doctors and dentists, and indeed to other middle-class groups in similar occupational situations and with similar values, further study is needed to establish this. My substantial findings of the effect of occupational roles on familial roles suggest that further study would in fact be fruitful. The differences I find between hospital doctors and dentists suggest the directions that further investigation could take. My findings may thus provide the basis for investigations starting with well-defined hypotheses and using large samples and sophisticated statistical techniques.
### TABLE 2:1  SAMPLE CHARACTERISTICS

<table>
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<tr>
<th></th>
<th>Hospital Doctors (n = 38)</th>
<th>General Dental Practitioners (n = 16)</th>
<th>Hospital Doctors' Wives (n = 38)</th>
<th>Dentists' Wives (n = 16)</th>
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</table>

| **Age**          |                         |                                      |                                  |                          |
| 23–26. 49 years | -                        | -                                    | 13                               | 25                       |
| 26.5–32.49 years| 68                       | 75                                   | 68                               | 56                       |
| 32.5–37 years   | 32                       | 25                                   | 13                               | 19                       |
| **Total**        | 100                      | 100                                  | 99                               | 100                      |

| **Family Size**  |                         |                                      |                                  |                          |
| 1 child          | 34                       | 38                                   |                                  |                          |
| 2 children       | 37                       | 44                                   |                                  |                          |
| 3/4 children     | 29                       | 19                                   |                                  |                          |
| **Total**        | 100                      | 101                                  |                                  |                          |

| **Duration of time since graduation** |                         |                                      |                                  |                          |
| 3–8 years        | 68                       | 81                                   |                                  |                          |
| 9–12 years       | 32                       | 19                                   |                                  |                          |
| **Total**        | 100                      | 100                                  |                                  |                          |

+ Status groups were defined to comprise the Registrar-General's socio-economic groups as follows:

**Status Group 1**: socio-economic groups 1, 3, 4, large land owners and officers in the armed forces.

**Status Group 2**: socio-economic groups 2, 6, 7, 8, 12, 13, and 14.

**Status Group 3**: 5, 9, 10, 11, 15, 16.
The main study was undertaken in the latter half of 1969 and in early 1970. Data was gathered mainly by means of in depth interviews lasting 2-4 hours and using closed and open questions as seemed appropriate, and by means of a diary of activities which respondents were asked to keep for a week. The diary material was used for the quantification of the amount of time spent in work, family and leisure. The measures used and difficulties encountered are discussed in an appendix to chapter VI.

The interview schedule was evolved through a series of pilot interviews which were undertaken at intervals during 1968 and 1969. As my area of study is largely uncharted, the early pilot interviews were only loosely structured so that I might discover those areas of the conflict between work and family life which were significant to my respondents rather than those presumed to be important by me. Following Merton's advice, interviews were allowed to develop naturally by leaving respondents to move from one subject to another and by using respondents' remarks as cues for further questions. As the pilot study progressed, the interviews became more structured. The schedule for the main study was eventually drawn up on the basis of the evidence these unstructured pilot interviews provided of the questions it was meaningful to ask.

Interviews are usually classified on an unstructured-structured continuum and data correspondingly classified as 'qualitative' or 'quantitative', 'hard' or 'real and deep'. The advantages and disadvantages of structured and unstructured interviews are fairly well established. The more structured the interview, the more reliable
the data and the more easily can the data be coded and analysed and empirically tested in the future by other interviewers. But quantitative data does not adequately convey the richness and complexity of social relationships. This may be more adequately done by unstructured interviews. Verbal descriptions of individual cases and of institutions can, Crebenik and Moser suggest, often give a more vivid, richer and, in a sense, deeper picture of life than the statistical tables to be found in conventional survey reports. But the disadvantage of this type of interview is one of bias in that the interviewer’s commitment to a particular point of view may, to a greater extent than in structured interviews, affect both the nature of the information elicited and the interpretation of that information.

Students of family life have in fact very frequently found that quantitative data yielded by structured interviews is inadequate for the analysis of familial relationships, and have therefore attempted to get the best of both worlds by combining in different ways the techniques of structured and unstructured interviews. Thus Young and Willmott supplemented the precise, quantitative but limited data they obtained through formal survey methods with ‘richer’ material obtained through informal, intensive interviews. Komarovsky found that the case study approach, by virtue of its flexibility, captures the intricacies of marital relationships, brings to light new patterns of relationships, and gives the reader something of the rich flavour of family life. She writes:

...the case material conveys to the reader some aspects of a generalisation which have not as yet been captured with scientific precision. Asked to comment upon a story about a wife who was dissatisfied because her husband did not talk to her in the evenings, 37% of the respondents took the side of the husband and accused the wife of being spoiled. (By following this summary statement with the comments of men and women in their own words the) reader now catches the
idiom and the tone of the remarks, the indignation and the humour, the reasons offered for the opinion, the associations of ideas and the depth of expressed convictions. All these facets may eventually be classified with statistical precision. In the meantime, while the study of marital interaction is still in its infancy, to deprive the student of such descriptions is often to leave him with too spotty and arid a portrayal.

This kind of material, she argues, can suggest hypotheses which can be checked by an examination and a count of cases, and can be used to provide internal evidence to buttress hypotheses which have been tested by statistical analysis.

My own approach to this problem was to use a structured interview schedule which contained both open and closed questions. Closed questions were used where simple, factual information was required or where the data elicited was to be scaled in some way. Open-ended questions were used to capture the intricacies and complexities of the inter-relationships between work and family life and of attitudes to work and to marriage. This use of open questions, though time-consuming (in terms both of interview time and of analysis), gave respondents freedom to express their ideas in their own way and to voice their feelings and thoughts unencumbered by a prepared set of replies. Conceptualisation and measurement issues are discussed when presenting the data.

Interviewing spouses together and separately.

During the pilot study husbands and wives were interviewed together and separately so as to explore the relative advantages of joint and separate interviews. It was eventually decided that husbands and wives should be interviewed separately. This decision was based on the following considerations.
1. Joint interviews tended to be tense if issues were raised which were a source of contention between husband and wife (and given the nature of the research project this would often be the case). This was embarrassing for one or other or both of the respondents. Further, joint interviews sometimes produced a situation in which one or other partner sought my support when a contentious matter was being discussed. I seemed less likely to be asked for my opinion on a contentious matter in separate interviews - in these husbands or wives aired their discontents and I needed to do no more than nod sympathetically.

2. Joint interviews tended to be very long - running to nearly five hours in some cases. They were, therefore, very exhausting - for my respondents as well as for myself.

3. Recording responses was more difficult in the joint interview situation, particularly where open-ended questions were concerned, since these often provoked quick exchanges or extended discussions between husband and wife.

4. The joint interviews were productive of 'instantaneous contamination'. This seemed to occur particularly where one partner had little to say on the question posed (where the question was an open-ended one) and he/she would echo the views of the other partner. On the other hand, contamination could also occur in the single interview situation since husband and wife were likely to talk over the interview situation between them, and, insofar as they did so, responses could be prepared. I sometimes had direct evidence of husband-wife discussion of the interview where, for example, husband and wife in the coffee session following the interview questioned each other about their
responses to my questions, or where a husband telephoned his
to discover what it had
all been about. But, although it is reasonable to assume that
husband and wife frequently discussed the interviews, the second
interviews produced little tangible evidence of the effect of the
first interview and I formed the distinct impression that discussion
of contentious issues was avoided. 

5. In joint interviews respondents were sometimes inhibited by the
presence of their partners. Husbands seemed particularly likely not
to acknowledge their devotion to work or to air their discontents
with their wives' attitudes towards the demands work made of them —
and to do this out of deference to their wives' feelings. On the
other hand the joint interview did produce situations in which a
respondent who perceived his/her spouse to be making an 'untruthful'
response intervened to 'correct' the response being given. This
might have been helpful, not in getting at the truth for it would
be impossible to say whether the response that was being given was
deliberately fabricated or represented perceived 'truth', but in
discovering those situations in which husbands and wives seemed to
have different perceptions of the way in which they were playing
their roles. This may be illustrated by a case in which a husband
was projecting an image of himself as a 'family man' and his wife
intervened to say, 'You know what your aim in life is - you want to
be a consultant'. (Her tone of voice conveyed more than her words.)
It would here be impossible to say whether or not this man genuinely
perceived himself to be a family man or was projecting this image
of himself out of deference to his wife or to my normative
expectations as he perceived them. But it is clear that his
wife did not perceive him as centering his life on the family.
On the basis of these considerations, I came to the conclusion that separate interviews were to be preferred. In making this decision I was particularly influenced by the fact that interview tension is likely to be high when husband and wife are interviewed together. However, separate interviews had two distinct disadvantages. In the first place, interviews tended to make potential respondents suspicious and may have increased the refusal rate. Secondly, separate interviews posed a particular problem in houses with only one living-room, for the partner who was not being interviewed had to find a 'bolt-hole'. I was on one occasion refused an interview because of this. On occasion I had perforce to interview the husband at work, or the wife during the day (and surrounded by her screaming children). On many occasions the problem resolved itself - in that the interview was arranged for an evening when the husband was on duty at hospital, or the wife was going out to an evening class. On some occasions the spare spouse retired to the kitchen or to bed.

Respondent reaction

The interview situation is, as Marie Corbin suggests, an artificial situation in which two people, hitherto unknown to each other, meet briefly so that one of them may find out as much as possible about certain areas of the other's life situation and attitudes. All sociological interviewing is thus, in greater or lesser degree, an invasion of privacy and, where the interviewer is, as I was, concerned with the exploration of marital relationships, he is invading a particularly sensitive and personal area of peoples' lives.

Success depends on the willingness of respondents to surrender their privacy to an outsider whose claims to be engaged on a worthwhile piece of sociological research they are not in a position to judge,
and whose discretion regarding the preservation of anonymity and confidentiality they cannot be sure of. Consequently, the reaction of respondents is of interest. Their reaction is reported on in terms of:

1. the interest displayed in the interviews;
2. hospitality;
3. the frankness of respondents;
4. reciprocity in the interview situation.

1. Interest displayed

I was both surprised and gratified by the friendliness, cooperation and interest displayed by respondents. Many wanted to know where they would be able to read up the results. Some expressed enjoyment of the interview. Some made suggestions regarding publication - several respondents suggesting publication in The Lancet or The British Medical Journal.

Husbands - particularly the hospital doctors - seemed to take a workmanlike interest in the project. I was questioned as to my sampling techniques and my plans for data analysis - some respondents clearly thought that the analysis of the open-ended questions would be a mammoth and problematic task. I was both complimented and quizzed on the pertinence and subtlety (or otherwise) of my questions.

The interest displayed by hospital doctors seemed in some cases to stem from the fact that the study explored issues which, as one doctor said, are frequently thrashed out by hospital doctors. My research was therefore seen as relevant to their lives and it is possible that some felt that my findings could be utilised in their struggle for better conditions of work.
In other cases, the hospital doctors' workmanlike interest in my research methods and results seemed to stem from the fact that they were themselves working in a semi-academic environment and were sometimes engaged in research. They were thus by no means naive subjects and were aware of the implications of my questions.

This is suggestive of a difficulty peculiar to sociological research in the professional middle classes. Insofar as the middle classes are not naive subjects, their responses may be tailored by their awareness of the implications of the questions asked and by their own evaluation of the study. At the same time, a respondent's own commitment to scientific discovery and objectivity entails (as comments sometimes suggest) a realisation of the importance of honesty and a willingness to co-operate with a fellow researcher.

The interest displayed by wives seemed to operate on a more 'personal' level. Many seemed quite simply to enjoy talking about themselves. For some the interview seemed to be a 'diversion', a novel event, something to tell their friends about. Others were pleased by the knowledge that their views and opinions were to constitute part of a thesis. They saw their participation in the project as status-enhancing and revelled in this enhancement of their status.

The different nature of the interest in the study displayed by husbands and wives is perhaps indicative of the gulf between the worlds of husbands and wives. The husbands' interest, deriving partly from an academic interest in research and partly from the relevance of the study to their occupational situation, illustrates the importance of work in their lives. The wives tended to treat the interview as a social event, something to tell their friends and neighbours about over cups of coffee.
2. **Hospitality**

The way in which I was received by my respondents was in itself an interesting commentary both on their attitudes to the interview and their style-of-life. I was treated as a guest by all respondents. I was frequently given a lift home and was usually offered refreshments. These ranged from coffee and biscuits to a delicious boeuf stroganoff. Some wives had obviously prepared for my visit. They dressed for the occasion. The refreshments with which I was plied seemed to have been specially prepared and in some cases there had, I suspect, been a tidying-up session before I arrived. Others, equally obviously, expected me to take them as I found them. In a few cases, the interview had been forgotten and my arrival was untimely. Thus, in one instance, I arrived to find a wife with her hair in rollers, her washing drying in front of the fire, and the ironing board up. She was fiercely embarrassed. I was very apologetic. Her husband was relieved, as my arrival enabled him to remove himself to the 'local' with a clear conscience.

In my role as 'guest', I was on occasion taken up to the nursery by husbands who were fathers for the first time of still very young infants and proudly shown 'the grand wee chap', 'the little man'. On another occasion, I was, with equal pride, shown the railway track which was the joy of one of my respondent's leisure hours.

On occasion - but largely as a result of long daytime interviews - I was involved in the household routine. For wives who were interviewed during the day, the length of the interview was disruptive of household routines. Sometimes the interview situation became fraught since children could seldom amuse themselves for more than an hour and would become fractious. With very young children, the interviews could encroach
upon feeding time. On such occasions I found myself endeavouring to beguile small children while asking questions (children's drawings in my notebooks bear eloquent testimony to my endeavours), bottle-feeding babies, and even washing up the breakfast dishes. In general mothers bore the disruption of their household routine with considerable fortitude but the effect must have been stressful for them — as indeed it was for me.

This kind of hospitality and involvement in the household made the interviews pleasurable, but posed a problem. For it was difficult to maintain polite conversation over coffee and at the same time maintain the detached and uncommunicative front necessary to avoid prejudicing responses.

3. Frankness

In general respondents answered questions freely, at great length and with apparent honesty. Some of the couples evidently enjoyed talking about themselves. Responses to structured questions were elaborated upon. Responses to open-ended questions were sometimes more detailed than they need have been. Sometimes, in elaborating responses, questions yet to be asked were forestalled. As a result, it was not always easy to keep the discussion to the topic in hand. It may be that reserve was actually broken down by the personal nature of some questions.

In fact, the interview became for some respondents an opportunity for unburdening themselves of grievances and frustrations. One wife told me that this was 'the first time for a long time that she had really had a chance to talk to anyone about herself and about the way she felt about things'. In unburdening themselves, husbands and wives sometimes also demanded reassurance and support. Thus two 'captive'
wives sought advice and information on ways out of their captivity, and one husband, who was clearly hurt by his wife's tendency to regard the area in which they lived as beneath the status to which she had been accustomed, took me on a conducted tour of their house, pointed out its many attractions and the improvements he had made, and anxiously asked me about the area and houses others of my respondents lived in. These respondents seemed to be, albeit unconsciously, using the interview as a therapy session.

However, although respondents were generally friendly, frank and fulsome, they could also be annoyed, embarrassed and threatened.

Annoyance at the length of the interview was displayed by some of the men. In three cases I was painfully aware that the interview interfered seriously with work schedules. A few respondents were clearly determined to get the interview over as quickly as possible by giving the briefest of responses. On one occasion resentment of the interview length was relayed to me by a wife who told me that I had made her husband late for an appointment and that I was, as a result, very unpopular with him. In this particular case, the interview had, in fact, been interrupted - and therefore lengthened - by an unexpected visitor.

Embarrassment and reticence were more often displayed by husbands than by wives. Husbands talked readily about their careers and attitudes to work. But they talked less readily about their marriage relationships. It was fairly obviously embarrassing to many of them to voice criticisms of their wives or to admit to being other than family-oriented or to family problems. Their embarrassment seemed to
stem from feelings of disloyalty in criticising their wives to a stranger and feelings of guilt concerning work-generated family problems.36

Wives seemed not to have similar inhibitions. They talked freely of marital problems and seemed convinced that they were justified in their grievances.

The difference in the ease with which husbands and wives spoke of work-generated family problems suggests that husbands felt themselves to be in a vulnerable position and that wives did not. That is, the diffidence of husbands implies tacit recognition that certain patterns of familial role performance are expected.

4. Reciprocity in the interview situation

All that I have said about the interviews indicates that the role of interviewer/researcher is not as sharply defined as might be expected. I was therapist and guest as well as interviewer. I also found that in this, as in all social relationships, reciprocity was expected. I asked a great deal of respondents of their time, their trust, their rights to privacy. But I was also expected to give. As researcher, my results were seen as a potential weapon in the battle for better conditions of work, and my interest was used as a status-winning device in social intercourse with friends and neighbours. As a guest, my appreciation of children, homes and hospitality was to be expected. In exchange for confidences, I both played therapist and unveiled something of myself, for I was in turn questioned about myself, my plans and my aspirations.
The reciprocal nature of the relationship was usually implicit. But it could become explicit. Thus, on one occasion, I found that my arrival for an interview with a husband was to be used as an opportunity for his wife to have an evening out. He was 'on call' and if he was 'called out', I was to act as babysitter.
CHAPTER III

Occupational and Familial Values

My exploration of the effect of the occupational role of the husband-father on family relationships began with an examination of occupational and familial values. This examination revealed differences between hospital doctors and general dental practitioners in orientations to work and to marriage and family life. In general, wives share their husbands' orientations to work so that the differences which exist between hospital doctors and general dental practitioners are paralleled by similar differences between doctors' wives and dentists' wives. By contrast, doctors' and dentists' wives tend to have much the same expectations of marriage and these expectations differ from those of their husbands in certain important respects.

The explanation of the origin of differences between hospital doctors and general medical practitioners and their wives in their orientations to work and marriage does not come within the ambit of this study. It is, however, important to note that neither occupational nor familial values can be regarded as the outcome of the occupational situations in which these men find themselves: the men are in particular occupational situations and the women are married to men in particular occupational situations as a result of decisions made in the past. These decisions, I contend, are made in the light of orientations they bring to work.²

ORIENTATIONS TO WORK

The work orientations of junior hospital doctors, of general dental practitioners and of their wives were explored by asking respondents how important they considered each of the following aspects of work to be:³
a. a good income;
b. a position of authority and responsibility which gives you/him the opportunity to make decisions;
c. a job people think well of;
d. self-fulfilment - the opportunity to do a job which you/he feel(s) you are/he is really good at;
e. the opportunity to be of service to the community;
f. security.

These items were chosen to take into account the importance attached to, firstly, various extrinsic work rewards (income levels, security, and status), and, secondly, various intrinsic work rewards (self-fulfilment, the exercise of authority, and the opportunity to be of service to the community). These indicators of an intrinsic/extrinsic orientation to work are commonly used in the literature.4

The way in which respondents rated these items is shown in Table 3:1. This table shows that the achievement of self-fulfilment - as defined by the opportunity to do a job which the worker feels he is really good at - is the only aspect of work which hospital doctors with any frequency declare to be very important. Their orientation to work is, essentially, one in which self-fulfilment is demanded of work and extrinsic rewards are only moderately valued.

By contrast, most dentists regard the intrinsic satisfactions to be derived from the exercise of authority, as well as self-fulfilment, to be very important.5 Further, they value the extrinsic rewards of work more highly than hospital doctors do. In fact, they declare income and security to be very important as frequently as they declare self-fulfilment to be very important. Their orientation seems to be one in which both intrinsic and extrinsic satisfactions are sought in work.6
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<td>Total</td>
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<td>99</td>
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</table>

1. N=15 since one dentist misunderstood the scoring procedure and his responses on this item were consequently discounted.
Wives, as a group, share their husbands' occupational values. In the first place, both doctors' and dentists' wives believe self-fulfilment in work to be very important - in fact they declare this aspect of work to be very important more frequently than their husbands do. Secondly, the differences that exist between hospital doctors and dentists in their evaluation of the extrinsic rewards of work are associated with similar differences between doctors' wives and dentists' wives. But wives differ from their husbands in their evaluation of authority. Dentists' wives less frequently than their husbands, and doctors' wives more frequently than theirs, regard authority as very important.7

The differences between hospital doctors' and general dental practitioners' orientations to work which are here revealed are likely to be reflected in career strategies.8 We may expect that the career strategies of hospital doctors will be oriented to maximising the intrinsic personal satisfactions to be derived from work and that they will not be particularly concerned with maximising those rewards (income and security) which are likely to benefit the family. The career strategies of dentists on the other hand may be oriented to achieving both personal satisfactions and the income and security rewards that are likely to benefit the family. We may also expect that where both intrinsic and extrinsic satisfactions are desired, career decisions involving a choice between job satisfaction and economic returns will be fraught with difficulty. These matters are explored further in Chapter IV.

We may also expect that wives' attitudes towards their husbands' involvement in work and the career strategies they pursue will reflect their evaluations of the rewards of work. The generally moderate
evaluation by wives of, on the one hand, the achievement of authority positions and, on the other hand, of income and status rewards, suggests that these wives do not regard the pursuit of success for its own sake as legitimate.

On the other hand, wives, while valuing only moderately the extrinsic rewards of work, attach a considerable importance to the achievement of self-fulfilment in work. This seems to suggest that they regard involvement in work for the sake of the intrinsic satisfactions it provides as legitimate. This question is explored further in subsequent chapters.

My findings regarding orientations to work have a more general significance on two counts.

Firstly, the marked differences in orientations to work as between two professional groups that are revealed suggest that 'global' comparisons as between the middle classes and working classes, of the type usually made in sociological research, may be misleading. Such comparisons may obscure differences between occupational groups within a stratum and may thus fail to reveal crucial links between structure, values and behaviour.

Secondly, the fact that dentists and their wives (and some hospital doctors and their wives) are clearly desirous of maximising both the intrinsic and extrinsic satisfactions of work suggests that the distinction customarily made between intrinsic and extrinsic orientations to work is a distinction between ideal-typical orientations rather than a classificatory instrument on the basis of which individuals, occupational groups or social class groups may be categorized. This is a point to which I shall return later.
ORIENTATIONS TO MARRIAGE

My exploration of the meaning of marriage and family life is based on the notion that orientations to marriage are defined by the expectations which each partner has of both his own role and his partner's role in marriage. To gauge the expectations which husbands have of their wives, and wives' definitions of their own roles, respondents were asked to say how important they considered each of the following to be in a wife's role:

a. making the home comfortable and keeping home life running smoothly;
b. being good with the children;
c. companionship: sharing leisure activities and interests with her husband;
d. being sympathetic and understanding;
e. being concerned that her husband should get what he wants out of work even if this means that he cannot be much involved in family life.

Similarly, respondents were asked to say how important they considered each of the following to be in the role of a husband:

a. helping with chores and doing things about the house and garden;
b. sharing with his wife responsibility for the children;
c. giving his wife a comfortable and attractive home and a decent and secure standard of living;
d. companionship - sharing leisure activities and interests with his wife;
e. being sympathetic and understanding.

These items were chosen to take into account, firstly, the dimensions by which the emerging partnership of husband and wife have commonly been defined (namely mutual emotional support, companionship, division of responsibility for children and the division of labour in the home);
secondly, the traditional functions of wife and husband (home-making and breadwinning); and thirdly, attitudes concerning a wife's role in relation to her husband's occupational role.

Tables 3:2 and 3:3 show the importance attached by husbands and wives to different facets of the roles of husbands and wives. Taken together, they provide a clear picture of the meaning of marriage and family life for these couples. I shall first consider the values of the group as a whole and then the differences between junior hospital doctors and general dental practitioners and between husbands and wives.

Emotional support is, clearly, the most valued facet of marriage: in the group as a whole the giving and receiving of sympathy and understanding is declared to be very important more frequently than any other aspect of marriage. This finding provides support for the suggestions, so frequently made in the literature, of the central importance of the expectation of emotional support in modern marriage.

Parenthood too, is valued: the parental roles of husbands and wives are declared to be important or very important by nearly all respondents. We might, however, have expected, in the light of suggestions made in the literature, to find parental roles declared very important rather more frequently.

Other facets of the marital relationship are, by comparison, little valued in that they are, on the one hand, said to be very important by relatively few respondents, and, on the other hand, said to be fairly important by relatively large numbers of respondents. The low evaluation of the traditional functions of marriage (breadwinning by husbands and home-making by wives) is suggested by the literature, but it is surprising to find that companionship, supposedly one of the main functions of marriage in the loose-knit structures of advanced industrial societies,
### Table 3.2: Importance Attached to Different Facets of a Wife's Role by Junior Hospital Doctors, General Dental Practitioners and Their Wives

<table>
<thead>
<tr>
<th>Aspect of the Wife Role</th>
<th>Doctors (n = 38)</th>
<th>Dentists (n = 25)</th>
<th>Doctors' Wives (n = 39)</th>
<th>Dentists' Wives (n = 16)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
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<tr>
<td>Housekeeping</td>
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<td>Total</td>
<td>101</td>
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</tbody>
</table>

| Care of the Children    |                 |                   |                         |                         |
| 1                       | 47              | 53                | 42                      | 66                      |
| 2                       | 47              | 40                | 58                      | 61                      |
| 3                       | 5               | 7                 | 12                      | 12                      |
| 4                       | -               |                   |                         |                         |
| Total                   | 99              | 100               | 100                     | 99                      |

| Companionship           |                 |                   |                         |                         |
| 1                       | 32              | 13                | 58                      | 38                      |
| 2                       | 45              | 53                | 26                      | 38                      |
| 3                       | 18              | 27                | 16                      | 19                      |
| 4                       | -               |                   |                         |                         |
| Total                   | 100             | 100               | 100                     | 101                     |

| Sympathy                |                 |                   |                         |                         |
| 1                       | 73              | 53                | 74                      | 63                      |
| 2                       | 24              | 40                | 24                      | 25                      |
| 3                       | 5               |                   | 3                       | 12                      |
| 4                       | -               |                   |                         |                         |
| Total                   | 100             | 100               | 101                     | 101                     |

| Support of Career Goals |                 |                   |                         |                         |
| 1                       | 29              | 13                | 42                      | 31                      |
| 2                       | 34              | 13                | 42                      | 44                      |
| 3                       | 26              | 6                 | 8                       | 6                       |
| 4                       | 11              | 20                | 8                       | 12                      |
| Total                   | 100             | 99                | 100                     | 100                     |

1. n = 18 since one dentist misinterpreted the scoring procedure and his responses on this item were consequently discounted.
### Table 3.3: Importance Attached to Different Facets of a Husband's Role by Junior Hospital Doctors, General Dental Practitioners and Their Wives

<table>
<thead>
<tr>
<th>Aspect of the husband role</th>
<th>Doctors (n = 37)</th>
<th>Dentists (n = 15)</th>
<th>Doctors' Wives (n = 38)</th>
<th>Dentists' Wives (n = 36)</th>
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<td><strong>99</strong></td>
<td><strong>100</strong></td>
<td><strong>101</strong></td>
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<tr>
<td>Responsibility for children</td>
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1. n = 34 as one doctor 'missed' this item.
2. n = 15 as one dentist misinterpreted the scoring procedure and his responses on this item were consequently discounted.
is not more frequently regarded as very important. It is also surprising, given the supposed general expectation of the sharing of domestic tasks, to find that participation by husbands in the work of the home is infrequently regarded as important, while wifely support for career goals is regarded as important by two-thirds of the sample even though this may entail a husband's non-involvement in the work of the home. This implies that for these couples the sharing of domestic tasks is not an important indicator of what they mean to each other, while wifely support for career goals is. This is a dimension of the marital partnership which is generally ignored in the literature, but the importance attached to it by these men and women suggests that it should in fact be considered.

Differences between hospital doctors and dentists in orientations to marriage

The foregoing discussion presents the general picture but obscures the fact that marked differences exist between junior hospital doctors and general dental practitioners, and between husbands and wives in their expectations of marriage and family life.

In the first place, it appears that dentists are more likely to find the meaning of family life in the possession of a comfortable home and in their children, while hospital doctors are somewhat more likely to find the meaning of family life in their relationship with their wives. This seems to be indicated by the fact that dentists are:

1. less likely to regard the smooth running of the home as a not particularly important aspect of a wife's role;
2. more likely to regard the provision of a comfortable and attractive home and a secure standard of life as an important aspect of a husband's role;
3. slightly more likely to regard the sharing of responsibility for children as a very important aspect of a husband's role;
4. slightly more likely to regard participation in the labour of the home as an important aspect of a husband's role.

The dentist's orientation to marriage is an interesting mixture of 'traditional' and 'modern', a mixture which suggests a particular orientation to family life - a home and family-centred orientation in which the comfort of the home, and the well-being of children, visible symbols of status and high earning capacity, are seen as important.

At the same time, hospital doctors are more likely than dentists to regard it as very important that:
1. husbands and wives should share leisure activities and interests with each other;
2. that husbands and wives should receive sympathy and understanding from each other;
3. that wives should be supportive of their husbands' career goals.
In sum, they seem more likely than dentists to place a high value on the marital relationship as intrinsically meaningful.

In the second place, hospital doctors and dentists appear to have different views of the relationship between their occupational and familial roles. Dentists far more frequently than hospital doctors see breadwinning, the provision of a comfortable home and a secure standard of living, as a very important facet of their familial roles. This difference in the importance attached to the breadwinning function is of a piece with differences in their orientations to work - with the fact that dentists more often than hospital doctors place a very high value on the extrinsic rewards of work.
This patterning of values points to different forms of interaction between work and family in different occupational groups. It suggests that where breadwinning is defined as a very important part of the husband role and, by implication, income and security are seen as necessary to the comfort and well-being of the family, the extrinsic rewards of work are highly valued. Work may here be seen as making an important contribution to family life and career goals may also be familial goals. But where - as in the case of hospital doctors - the breadwinning role is not defined as very important and, by implication, the maintenance of material standards is not seen as essential to family well-being - the extrinsic rewards of work are not highly valued. Occupational success is not here seen as contributing importantly to family life. Thus career goals may not also be familial goals.

In the light of the foregoing, it is a little surprising to find that dentists less frequently than hospital doctors attach great importance to support for career goals as a facet of a wife’s role. This implies no necessary connection between the high valuation of the breadwinning role and the expectation of wifely support for career goals. Nor can the definition of the achievement of self-fulfilment in work as very important be seen as 'fitting' the hospital doctors' greater expectation of wifely support for career goals since dentists as well as hospital doctors value self-fulfilment. However, as reported in later chapters, hospital doctors are, in fact, more likely to experience work as satisfying. Further, work is more likely to impinge on family life in hospital medicine. It may be that the hospital doctor’s greater expectation of wifely support for career goals is to be explained in terms of these two factors.
Differences between husbands and wives in orientations to marriage.

The differences which exist between hospital doctors and dentists do not, in general, also exist as between doctors' wives and dentists' wives. Both doctors' wives and dentists' wives have much the same orientation to marriage and family life. Correlatively, their orientations differ from their husbands'.

It is in fact among wives rather than among husbands that the strongest definition of marriage as a partnership appears. This is indicated by the fact that wives are more likely than husbands to believe it to be very important that:

1. husbands and wives share leisure time interests with each other;
2. husbands and wives be sympathetic and understanding;
3. husbands should participate in child-rearing.

In other words wives to a greater extent than husbands regard the marital relationship as intrinsically meaningful. These differences between husbands and wives in attitudes to marriage are greater between dentists and their wives than between hospital doctors and their wives, given that dentists less often than hospital doctors define the marital relationship as intrinsically meaningful.

However, for wives as for husbands definitions of the marital partnership would not appear to include a high valuation of the active participation of husbands in the business of familial life. This is indicated by the fact that:

1. most wives see their traditional home-making functions as important;
2. wives infrequently - and even less frequently than their husbands - regard it as important that husbands help with domestic and garden chores;
3. Wives frequently - and more frequently than husbands - regard wifely support for career goals as important, even where the pursuit of career goals entails a husband's non-participation in familial life.

As I suggested earlier, this finding shows that the sharing of familial tasks, which the literature suggests is an important feature of modern western marriage, is not in fact important to these upper middle-class men and women. It may be that they consider the problems of household management to be more appropriately solved by the employment of domestic helps and handymen.

Wives, I have suggested, value the marital relationship in itself. But they also value parenthood. This is suggested both by their high valuation of the sharing of responsibility for the children and also by the fact that most wives regard it as very important that wives should be good with the children. Dentists as a group share their wives' valuation of the parental role but the views of hospital doctors are at variance with the views of their wives.

Finally, wives tend to value only moderately the breadwinning dimension of the husband role. This moderate valuation of the breadwinning function is shared by doctors but not by dentists and 'fits' their valuation of the income rewards of work. Yet, even though few wives declare breadwinning to be very important and many wives say it is only fairly important, most wives (and doctors' wives to a greater extent than dentists' wives) regard support of their husbands' career goals as an important or very important dimension of their role. This apparent incompatibility may be resolved by the fact that though they value only moderately the economic rewards of work, they attach
a considerable importance to the achievement of self-fulfilment in work.

However, there is a certain ambivalence in the attitudes of wives, for wives desire that their husbands should both achieve self-fulfilment in work and share with them leisure activities and responsibility for children. But it may be difficult for both these sets of aspirations to be realised where the pursuit of self-fulfilment in work is time-consuming. The way in which this ambiguity may affect reactions to the impingement of work on family life is explored in Chapter VII.

It is, I am suggesting, the pursuit of self-fulfilment in work rather than the pursuit of economic goals per se that wives legitimate by the definition of their role as involving support for career goals.

Summary

I have, in this chapter, explored the expectations which junior hospital doctors, general dental practitioners and their wives have of work, marriage and family life.

This exploration suggests that, while both hospital doctors and general dental practitioners place a high value on the achievement of self-fulfilment in work, dentists to a greater extent than hospital doctors place a higher value on the economic rewards of work. Correlatively, dentists place a higher value on the breadwinning aspect of their familial roles. I have suggested that the differences between hospital doctors and dentists in their orientations to work may entail the pursuit of differing career strategies with differing implications for family life. I have also suggested that the high valuation by dentists of the economic rewards of work may mean that for dentists career goals are also familial goals but that this may not be so for hospital doctors.
A little surprisingly (given their higher valuation of the economic rewards of work), dentists, in their definitions of the 'good wife', place a lower value than hospital doctors do on wifely support for career goals. It is suggested that this difference in the valuation of wifely support for career goals may reflect (a) the fact that hospital doctors to a greater extent than general dental practitioners actually experience satisfaction in work and (b) that work impinges on family life to a greater extent in hospital medicine than in general dental practice.

Family orientations suggest that general dental practitioners have a basically home-and child-centred orientation to family life, while hospital doctors tend to value the satisfactions to be derived from the marriage relationship itself. However, both hospital doctors and general dental practitioners seem to have less strong definitions of marriage as a partnership than their wives. Wives' conception of marriage as a partnership involves not so much the participation of husbands in domestic chores as the sharing of emotional concerns, companionship and the sharing of responsibility for children.

At the same time, the expectations which wives have of marriage as a partnership may clash with the importance they attach to the achievement of self-fulfilment in work and their tendency to define their own roles as involving support for the career goals of their husbands. This indicates a tension in the occupational and familial values of wives which, it is suggested, may affect their reactions to the impingement of work on family life.

I now turn to the examination of the implications for family life and for the performance of the husband-father role of the occupational situation of hospital doctors and general dental practitioners and of the career strategies they pursue within the context both of that occupational situation and of their expectations of work.
The occupational situation of the hospital doctor differs from that of the general dental practitioner in certain important respects. The hospital doctor works in a large-scale, hierarchically-structured organisation in which 'success' depends on promotion up a career ladder and the attainment of consultant status. The general dental practitioner is, by contrast, an independent professional for whom 'success' depends on building up a local reputation and clientele.

These contrasting career structures and their differing implications for the performance of the breadwinning aspect of the husband-father role will now be examined in detail. Thereafter attitudes towards earning power and strategies for resolving the disjunction between earning power and consumer aspirations will be discussed.

CAREER STRUCTURES

1. The structure of opportunity in hospital medicine

The career structure in the hospital service is based on the tradition of consultant responsibility developed in the teaching hospitals and confirmed by the Spens Committee and the Platt Working Party. Under this system full clinical responsibility and independence is accorded only to consultants and pre-consultant grades are regarded as training grades. This means that succession to a consultancy is the only mark of successful completion of a lengthy apprenticeship. This system brings with it (a) insecurity and (b) low earning power during the early stages of the career cycle - a stage that in our society tends to coincide with the home-making and family-building stage of the family life-cycle.
a) **Insecurity**

Although the pre-consultant grades were designed by the Spens Committee to be training grades for consultant status in the various medical specialisms, they are in practice used primarily for service purposes - that is to provide for the routine care of patients. Thus the number of doctors in these grades has come to be related to service needs rather than to opportunities for promotion and, as a result, to be greater than the number for whom consultant posts are likely to be available.

Examining this situation in 1967, Brotherston found that maintenance of the existing level of consultant staffing and of the rates of growth which had obtained in the previous two years would require less than half of the registrars then working in hospitals. In other words, less than half of young doctors in hospital could in fact look forward to consultant status in a career structure in which full clinical responsibility is the only mark of successful completion of a lengthy apprenticeship. Competition is consequently intense and career opportunities are, to a considerable extent, facilitated by getting on to a 'good circuit' - that is on to a unit with chiefs of established reputation.

One by-product of this situation is that succession to consultant status takes place at a later age than that envisaged by either Spens or Todd. Both the Spens Committee and the Todd Commission suggested that the period of post-graduate training and experience required to achieve an acceptable level of competence in a speciality would be of the order of eight years (with some variation between specialities). But various studies show that the period of training from the time of qualification to the time of attaining a consultant appointment is usually 12-14 years. Thus
where Spens envisaged that consultant status would generally be obtained at age 32, the average age of appointees to consultant status in both Scotland and England and Wales in 1969 was 38 years. 8

The uncertainties and intense competitiveness inherent in this career situation are exacerbated by the fact that tenure of posts in the sub-consultant grades is limited: to six months for each of the two pre-registration posts and to a maximum of one year for SHO posts, three years for posts in the registrar grade and four years for posts in the senior registrar grade. 9 These limitations on tenure of posts mean that junior hospital doctors do not enjoy security of office and are frequently involved in a time-consuming and intensely competitive hunt for jobs. Success in this hunt for jobs depends not only on merit but also on chance as represented by age at the time of the vacancy, coincident technical training, building developments and so on. 10

A career in hospital medicine is rendered uncertain not only by the imbalance between junior posts and consultant posts and the limited tenure of sub-consultant posts, but also by the need to obtain a higher qualification by passing examinations organised by the professional medical colleges for the formal purpose of selecting doctors for admission to membership. The failure rate in these examinations is high (Table 4:1) and bears eloquent testimony, as the Todd Commission suggests, to the inappropriateness of much postgraduate experience to training needs, and to the inadequacy of facilities (including the availability of time) for study. 11 Further, the lack of complete reciprocity between the English and Scottish colleges imposes, in the words of the Todd Commission, 'a highly undesirable rigidity on appointments in Britain'. 12 As Todd points out, candidates with an
TABLE 4.1 HIGHER QUALIFICATIONS OF THE SPECIALIST PROFESSIONAL COLLEGES: PASS RATES IN RECENT EXAMINATIONS

<table>
<thead>
<tr>
<th>Entries and Pass Rates of all Colleges, 1964-66</th>
<th>Primary Examination</th>
<th>Final Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Entries</td>
<td>% Successful</td>
</tr>
<tr>
<td>Royal College of Physicians (M.R.C.P.(Lond.))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>not applicable</td>
<td>1,749</td>
</tr>
<tr>
<td>1965</td>
<td>1,327</td>
<td>39</td>
</tr>
<tr>
<td>1966</td>
<td>2,056</td>
<td>33</td>
</tr>
<tr>
<td>Royal College of Surgeons of England (F.R.C.S.(Eng.))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>1,238</td>
<td>26</td>
</tr>
<tr>
<td>1965</td>
<td>1,265</td>
<td>27</td>
</tr>
<tr>
<td>1966</td>
<td>1,261</td>
<td>27</td>
</tr>
<tr>
<td>Royal College of Physicians of Edinburgh (M.R.C.P.(Edin.))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>not applicable</td>
<td>1,412</td>
</tr>
<tr>
<td>1965</td>
<td>309</td>
<td>30</td>
</tr>
<tr>
<td>1966</td>
<td>1,024</td>
<td>67</td>
</tr>
<tr>
<td>Royal College of Surgeons of Edinburgh (F.R.C.S.(Edin.))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>226</td>
<td>32</td>
</tr>
<tr>
<td>1965</td>
<td>238</td>
<td>30</td>
</tr>
<tr>
<td>1966</td>
<td>249</td>
<td>39</td>
</tr>
<tr>
<td>Royal College of Physicians &amp; Surgeons of Glasgow (M.R.C.P.(Glasc.))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>not applicable</td>
<td>693</td>
</tr>
<tr>
<td>1965</td>
<td>234</td>
<td>32</td>
</tr>
<tr>
<td>1966</td>
<td>549</td>
<td>27</td>
</tr>
<tr>
<td>1965</td>
<td>449</td>
<td>27</td>
</tr>
<tr>
<td>1966</td>
<td>404</td>
<td>32</td>
</tr>
</tbody>
</table>

Cont...
TABLE 4:1 Continued...

<table>
<thead>
<tr>
<th></th>
<th>Primary Examination or Part I</th>
<th>Final Examination or Part II</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Entries</td>
<td>% Successful</td>
</tr>
<tr>
<td>Royal College of Obstetricians &amp; Gynaecologists (M.R.C.O.G.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1965</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| College of Pathologists (M.C.Path.) |                      |                          | 67 | 45            |
| 1964 | 81 | 42 | 67 | 45 |
| 1965 | 220 | 41 | 112 | 49 |
| 1966 | 172 | 53 | 86 | 44 |


English higher diploma are likely to be preferred in England (though the converse does not hold). As a result Scottish graduates, who constitute about a quarter of the British total and many of whom must leave Scotland to secure hospital appointments, often find that they must spend time and money seeking the qualifications of an English as well as of a Scottish college.

Alternative prospects for the failed hospital doctor do, of course, exist in general practice. But entry into general practice becomes increasingly difficult the longer the hospital doctor remains in the hospital service in the hope of achieving consultant status. Extended experience of hospital medicine means that the hospital doctor may become too specialised readily to find an appointment in general practice. This is particularly the case in surgery.13
Alternative career opportunities exist for some few doctors in community medicine, industry and the universities. University pre-clinical departments offer some opportunities for teaching and research while the clinical and para-clinical departments provide some opportunities for working in hospitals as well as for teaching and research. Such posts tend to appeal to the research-oriented, but are also used as a means of side-stepping the insecurities of N.H.S. Hospital Medicine in that a hospital doctor may take a university post with a view to returning to the N.H.S. at a more senior level.  

In the past unplaced trainees could find scope for their skills by transferring to, for example, the Colonial Service or the Armed Services. But the needs of the Colonial Service and the Armed Services are now so reduced that they are no longer a significant outlet.  

b) Earning Power

The insecurity and competitiveness of a career in hospital medicine is accompanied by relatively low salaries in the training grades.  

In the 1950s and early 1960s the salary structure in hospital medicine bore the imprint of the pre-1948 situation in that salary scales were based on the conception of the pre-consultant grades as training grades. As a result starting salaries were low and generally compared unfavourably with starting salaries in other professions. Further, during the 1960s the value of remuneration in the hospital service was effectively reduced by the increase in the average age of doctors at appointment to the consultant grade. This meant that hospital doctors were nearly 40 when they achieved consultant salaries.
In 1966 this approach to the remuneration of junior hospital doctors was modified. In that year the Kindersley Review Body on Doctors’ and Dentists’ Remuneration\textsuperscript{19} came to the conclusion that it was:

no longer either consistent with realities and with current thinking and practice in professional remuneration, or fair to those concerned, to pay the most junior grades of hospital doctors at rates which are manifestly not only out of line with rates paid to people of similar age and comparable qualifications in other professions but also out of proportion to the amount of work they are expected to do.\textsuperscript{20}

So, on the recommendation of the Review Body, salaries were increased substantially. Salary scales pertaining to the 1960s are shown in Table 4\textsuperscript{21}.

But in spite of this and other improvements in income, the level of remuneration of junior hospital doctors - like that of other medical and dental men in the N.H.S. - lagged behind increases won by comparable professional groups during the 1960s to such an extent that the Kindersley Review Body, when reviewing remuneration in 1970, recommended a general increase of 30\% so that the relativities set up by Pilkington in 1960 could be re-established.\textsuperscript{22}

Even so, a subsequent analysis by the Halsbury Review Body of the effect of these increases on the comparative position of doctors and dentists showed that, in the period between the Pilkington Report (1960-61) and 1971, increases in the salaries of registrars, senior registrars and consultants lagged behind increases won by professional groups whose income had been similar to theirs in 1960. On the other hand, house officers and senior house officers improved their position (Table 4\textsuperscript{23}).
### TABLE 4.2  EARNINGS OF HOSPITAL DOCTORS AT SELECTED INTERVALS 1955-70

<table>
<thead>
<tr>
<th>Grade</th>
<th>Scale 1955-56</th>
<th>Implemented from 1955-56</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1.60</td>
<td>1.4.63</td>
</tr>
<tr>
<td></td>
<td>1.10.66</td>
<td>1.1.69</td>
</tr>
<tr>
<td></td>
<td>1.4.70</td>
<td></td>
</tr>
<tr>
<td>House</td>
<td>425</td>
<td>675</td>
</tr>
<tr>
<td>Officer</td>
<td>475</td>
<td>750</td>
</tr>
<tr>
<td></td>
<td>525</td>
<td>825</td>
</tr>
<tr>
<td>Senior</td>
<td>745</td>
<td>1,030</td>
</tr>
<tr>
<td>House</td>
<td>27 or 27</td>
<td>1,195</td>
</tr>
<tr>
<td>Officer</td>
<td>28 or 28</td>
<td>1,550</td>
</tr>
<tr>
<td>Senior</td>
<td>750</td>
<td>2,425</td>
</tr>
<tr>
<td>Registrar</td>
<td>850</td>
<td>1,125</td>
</tr>
<tr>
<td>Senior</td>
<td>1,100</td>
<td>1,710</td>
</tr>
<tr>
<td>Registrar</td>
<td>1,200</td>
<td>1,500</td>
</tr>
<tr>
<td></td>
<td>1,300</td>
<td>1,700</td>
</tr>
<tr>
<td></td>
<td>1,400</td>
<td>1,800</td>
</tr>
<tr>
<td></td>
<td>1,900</td>
<td>2,165</td>
</tr>
<tr>
<td></td>
<td>2,000</td>
<td>2,165</td>
</tr>
<tr>
<td></td>
<td>2,000</td>
<td>2,490</td>
</tr>
<tr>
<td></td>
<td>2,000</td>
<td>2,490</td>
</tr>
<tr>
<td></td>
<td>2,100</td>
<td>2,550</td>
</tr>
<tr>
<td>Consultants</td>
<td>2,100</td>
<td>2,550</td>
</tr>
<tr>
<td></td>
<td>2,550</td>
<td>2,910</td>
</tr>
<tr>
<td></td>
<td>at age</td>
<td>x 185 (5)</td>
</tr>
<tr>
<td></td>
<td>32 or 34</td>
<td>x 200 (8)</td>
</tr>
<tr>
<td></td>
<td>over x</td>
<td>x 201 (8)</td>
</tr>
<tr>
<td></td>
<td>125 (8)</td>
<td>x 190 (4)</td>
</tr>
<tr>
<td></td>
<td>= 3100</td>
<td>x 5,275 (4)</td>
</tr>
<tr>
<td></td>
<td>3,750</td>
<td>4,270</td>
</tr>
<tr>
<td></td>
<td>3,900</td>
<td>4,445</td>
</tr>
</tbody>
</table>

1. Lowest salary point not linked to age.
### TABLE 4:3 MOVEMENTS IN DOCTORS' AND DENTISTS' EARNINGS COMPARED WITH CORRESPONDING PERCENTILES AT APRIL 1971

(indices: 1960/61 = 100)

<table>
<thead>
<tr>
<th>Earnings April 1971</th>
<th>Corresponding percentile April 1971</th>
<th>Shortfall (-) or excess (+) of earnings relative to percentile $(a) - (b)$ as percentage of $(a)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Percentile</td>
<td>Index (b)</td>
</tr>
<tr>
<td>House officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>241</td>
<td>50th</td>
</tr>
<tr>
<td>(maximum)</td>
<td>228</td>
<td>50th</td>
</tr>
<tr>
<td>Senior House Officer (minimum)</td>
<td>185</td>
<td>25th</td>
</tr>
<tr>
<td>Registrar (&quot;n&quot;)</td>
<td>186</td>
<td>25th</td>
</tr>
<tr>
<td>Senior registrar (minimum)</td>
<td>184</td>
<td>10th</td>
</tr>
<tr>
<td>(4th point)</td>
<td>180</td>
<td>10th</td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>177</td>
<td>2.5th</td>
</tr>
<tr>
<td>(maximum)</td>
<td>175</td>
<td>1.5th</td>
</tr>
<tr>
<td>(with C award)</td>
<td>175</td>
<td>1st</td>
</tr>
<tr>
<td>General medical practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(recommended)</td>
<td>231</td>
<td>5th</td>
</tr>
<tr>
<td>(actual)</td>
<td>237</td>
<td>5th</td>
</tr>
<tr>
<td>General dental practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(target)</td>
<td>194</td>
<td>5th</td>
</tr>
</tbody>
</table>


Whatever their position in the training grades, hospital doctors may look forward to relatively substantial earnings when they attain consultant status (see Table 4:2). At this level, basic income may be augmented by earnings from private practice and by Distinction Awards. The distinction award represents a device whereby the concept of an undifferentiated consultant grade is maintained while individual merit is awarded and a significant minority of doctors are given an opportunity for earning incomes comparable with the highest that can be earned in other professions.
However, the percentage of consultants who increase their earning power substantially either by winning a Distinction Award or by private practice is probably small. As Table 4:4 shows, only a small percentage of doctors receive awards that are particularly large (A or B awards). As far as private practice is concerned, hospital doctors claim that only a small percentage of consultants earn substantial sums from private practice since (a) opportunities for private practice is, in many specialties and regions, limited and (b) 76% of all consultants derive the whole or almost the whole of their earned income from the N.H.S. since whole-time consultants are precluded by their terms of contract from undertaking work outside the N.H.S., and maximum part-time consultants undertake to give virtually the same amount of time to the N.H.S. as a full-time consultant and thus have very little time in which to undertake work outside the N.H.S. 25

Moreover, consultants who earn really substantial incomes probably do so only late in life. As Table 4:5 shows, the percentage of consultants receiving A or A-plus awards before the age of 50 is very small. Substantial incomes from private practice are probably also earned only relatively late in life.

<table>
<thead>
<tr>
<th>Type of Award</th>
<th>% consultants holding Awards in England &amp; Wales</th>
<th>% consultants holding Awards in Scotland</th>
<th>Amount of Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plus</td>
<td>.9</td>
<td>.9</td>
<td>£5,275</td>
</tr>
<tr>
<td>A</td>
<td>3.2</td>
<td>3.2</td>
<td>£4,000</td>
</tr>
<tr>
<td>B</td>
<td>9.6</td>
<td>9.6</td>
<td>£2,350</td>
</tr>
<tr>
<td>C</td>
<td>19.7</td>
<td>19.7</td>
<td>£1,000</td>
</tr>
<tr>
<td>Total</td>
<td>33.4</td>
<td>33.4</td>
<td></td>
</tr>
<tr>
<td>Total No. of consultants</td>
<td>9891</td>
<td>1541</td>
<td></td>
</tr>
</tbody>
</table>


TABLE 4:5 AGE OF CONSULTANTS RECEIVING DISTINCTION AWARDS IN 1969 
FOR THE FIRST TIME

<table>
<thead>
<tr>
<th>Age</th>
<th>A plus Awards</th>
<th>A Awards</th>
<th>B Awards</th>
<th>C Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>45 - 49</td>
<td>-</td>
<td>16</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>50 - 54</td>
<td>13</td>
<td>31</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>38</td>
<td>53</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Totals %</td>
<td>101</td>
<td>100</td>
<td>100</td>
<td>101</td>
</tr>
<tr>
<td>N</td>
<td>16</td>
<td>49</td>
<td>144</td>
<td>338</td>
</tr>
</tbody>
</table>

In Scotland ++

<table>
<thead>
<tr>
<th>Age</th>
<th>A plus Awards</th>
<th>A Awards</th>
<th>B Awards</th>
<th>C Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td>45 - 49</td>
<td>-</td>
<td>11</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>50 - 54</td>
<td>-</td>
<td>36</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>Over 55</td>
<td>100</td>
<td>33</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>N</td>
<td>2</td>
<td>9</td>
<td>29</td>
<td>57</td>
</tr>
</tbody>
</table>

++ Source: Statistics supplied me by the Scottish Home & Health Dept.

In sum, the career structure in hospital medicine leads to insecurity and poor earning power during the early stages of the career cycle.

Now these conditions of work are, prima facie, unfavourable to the performance of family breadwinning functions. Because the hospital doctor's tenure of office is on a short-term basis and the achievement of consultancy status uncertain, the family's financial security is not assured until consultant status is in fact achieved. Further (and to a greater extent during the 1950s and 1960s, when the hospital doctors I studied entered the hospital service, than at present),
the income the hospital doctor earns for his family is low during the period of the family life-cycle when expenditure is greatest - that is during the home-making and family-building period when a house must be bought and furnished and children are born and, as they mature, must be sent to nursery school and then to primary school. In effect, rewards from the occupational system are so phased as to be out of step with the patterning of consumption needs in the family system. There are thus structured incompatibilities between the occupational system and the family system.27

2. The structure of opportunity in general practice

The disjunction that exists in hospital medicine between occupational rewards and family consumption demands is not unique. Hospital medicine represents in an extreme degree the competitiveness and insecurity which are to be found in varying degrees in many occupations - professional and non-professional, working class and middle class. The peaking of monetary rewards in the dispersal stage of the family life-cycle is, as I suggested earlier,28 of the essence of a career situation.

However, in general medical practice - which represents an alternative career path for young doctors - occupational rewards are better 'fitted' to the cycle of family consumption demands.29 This is also true of general dental practice which I have chosen to study as a foil to hospital medicine.30

In the first place, a career in general practice - medical or dental - is secure and relatively uncompetitive. Entry into general practice is comparatively easy: in medicine there is a chronic manpower
Tenure of office is secure in both occupations and, indeed, the apprenticeship period over, doctors and dentists may remain in the same job until they retire. Occupational stability is, in fact desirable since income depends, not on career climb, but on building up and retaining a local reputation and clientele. Further, as independent professionals having no career ladder to climb, their "career" summit is assured and is achieved early in the life-cycle. Thus in both occupations - in contradistinction to hospital medicine - the breadwinner's family is protected from disruptions in, and fears of disruption in, income and from uncertainty as regards their future.

In the second place, income is high during the home-making and family-building stage of the life-cycle. As independent professionals, general medical and dental practitioners are not salaried, but receive fees for their professional services. However, fees for both general medical and general dental practitioners are fixed at levels intended to ensure that a specified average net income will be achieved after practice expenses have been met. Recommended net income levels pertaining in the 1960s are shown in Table 4:6.

Under this system of remuneration, there is little difference in earning power at different points in the life cycle. Thus general medical and dental practitioners' income during the family building stage of the life-cycle is high not only in relation to what it will be in the family dispersal stage of the life-cycle, but also in relation to the earnings of junior hospital doctors whose income, like that of most salaried professionals, peaks in the family dispersal stage of the life-cycle. In fact, of the professions whose incomes were analysed
## Table 4.6: Earnings of General Medical and Dental Practitioners at Selected Intervals 1955 - 70

<table>
<thead>
<tr>
<th></th>
<th>1955/56</th>
<th>60/61</th>
<th>63/64</th>
<th>66/67</th>
<th>69/70</th>
<th>70/71</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Practitioners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target average net income</td>
<td>1975</td>
<td>2425</td>
<td>2765</td>
<td>3700</td>
<td>4000</td>
<td>4800</td>
</tr>
<tr>
<td>Actual average net income:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>from NHS general practice</td>
<td>1967</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>from all official sources</td>
<td>1975</td>
<td>2765</td>
<td>2765</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>from all sources</td>
<td>2102</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Dental Practitioners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target average net income</td>
<td>2000</td>
<td>2400</td>
<td>2740</td>
<td>3200</td>
<td>3590</td>
<td>4308</td>
</tr>
<tr>
<td>Actual average net income:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>from NHS general practice</td>
<td>2165</td>
<td>2676</td>
<td>2699</td>
<td>3393</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>from all sources</td>
<td>2273</td>
<td>2793</td>
<td>2773</td>
<td>3462</td>
<td>3762</td>
<td>-</td>
</tr>
</tbody>
</table>

1. Under the Central Pool System (see note 3 to this chapter), the recommended target income included income from all official sources, and actual income was equal to recommended income. With the abolition of the Pool System recommendations related to NHS general practice income only and it became possible for actual average incomes to diverge from recommended average incomes. The Kendersley Review Body did not in fact state the average net income which it hoped to achieve by its recommendations (though various indications were given). The figures shown for 1966, 1969 and 1970 represent the Halsbury Review Body's interpretation of the recommendations of the Seventh, Tenth and Twelfth Kendersley reports.

2. From survey on incomes carried out by the Royal Commission on Doctors' and Dentists' Remuneration. See the Report of the Royal Commission, Cmnd 939 (p. 260), HMSO 1960.


4. This disjunction between the recommended target income and actual income is to be explained by (1) the postponement of half the recommended increase to April 1, 1967 and (2) the deferment of all increases to October 1, 1966 for reasons of incomes policy. But apart from this, GPs incomes tended in the period 1966-70 to be less than the recommended target, and in the period since 1970 to exceed the recommended target.

5. Provisional. 

by the Halsbury Review Body in 1972, hospital doctors' earnings show
the widest spread over the lifespan, typically reaching their peak only
after age 55, while general practitioners' earnings (which vary little
after age 35) show the least spread. The earning power of general
practitioners over the career cycle is thus better fitted to the cycle
of family consumption demands.

Moreover, income increases won by general medical practitioners
in the period between Pilkington (1960-61) and 1971 are greater than the
increases won by hospital staff and by general dental practitioners
(Table 4:3 and, further, have tended to outstrip increases won by other
professional workers whose incomes were similar to theirs in 1960-61.
This favourable position is the result of substantial increases awarded to
general medical practitioners in 1966 to increase the relative
attractiveness of general practice vis-a-vis hospital medicine and
thereby encourage recruitment to general practice.

Even so, the earning power of consultants is so substantial that
the total career earnings of hospital doctors probably exceed those of
both general medical practitioners and general dental practitioners.
The extent of this excess depends on whether or not Distinction Awards
and private practice earnings are taken into account.

Table 4:7 (a) compares the life-time earnings of full-time
consultants on the basic salary scale (that is, of consultants who are
not in receipt of either Distinction Awards or private practice earnings)
with the life-time earnings of general medical and dental practitioners
from N.H.S. general practice. As this table shows, the income of
the hospital doctor under 40 is considerably less than that of general
medical and dental practitioners. But from the age of 40 onwards the
TABLE 4:7  CAREER EARNINGS OF HOSPITAL DOCTORS AND GENERAL MEDICAL AND DENTAL PRACTITIONERS FROM N.H.S. SOURCES ON THE BASIS OF 1969 INCOMES

<table>
<thead>
<tr>
<th>Age</th>
<th>Hospital Doctors</th>
<th>General Medical Practitioners</th>
<th>General Dental Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appointment</td>
<td>Salary</td>
<td>Average net income</td>
</tr>
<tr>
<td>28</td>
<td>Registrar</td>
<td>1,790</td>
<td>2,705</td>
</tr>
<tr>
<td>29</td>
<td>&quot;</td>
<td>1,900</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>&quot;</td>
<td>2,010</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>&quot;</td>
<td>2,120</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>&quot;</td>
<td>2,220</td>
<td>3,840</td>
</tr>
<tr>
<td>33</td>
<td>Senior Registrar</td>
<td>2,355</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>&quot;</td>
<td>2,490</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>&quot;</td>
<td>2,625</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>&quot;</td>
<td>2,760</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>&quot;</td>
<td>2,760</td>
<td></td>
</tr>
</tbody>
</table>

28-37 Total: 23,030 37,265 35,900

38  Full-time Consultant^4 3,470 3,670

40- 44  4,270 21,350

45- 49  5,153 3,840 103,680 3,590 96,930

50- 64  5,275 25,765 79,125

52-64 Total: 133,380 103,630 96,930

28-64 Total: 156,410 140,945 132,830


1. Figures for actual income are not available. Actual income probably approximated target income.

2. See note 40 to this chapter.

3. Average net income for all ages. This figure may state earnings between 29-64 since earnings are at their lowest under 29 and over 64. However, the number of doctors in these age groups is small. It should be noted that average net income was below the intended net income (£4,000).

4. Incomes shown here are the basic salary scale.

hospital doctor earns more than the doctor or dentist in general practice by ever increasing amounts. Thus, ultimately, his total career earnings exceed those of both general medical and general dental practitioners.
However, he will not have earned as much as the general practitioner until he is nearly 55 and his total earning power is not substantially greater than that of the general medical practitioner. 38

Table 4:7 (b) takes account of the effect of Distinction Awards (by showing the average annual net income of consultants instead of their basic salaries). The same pattern of earnings over the life-span is revealed, but the hospital doctor's 'excess' earnings are now shown to be rather more substantial.

| Table 4:7 CAREER EARNINGS OF HOSPITAL DOCTORS AND GENERAL MEDICAL AND DENTAL PRACTITIONERS FROM N.H.S. SOURCES ON THE BASIS OF 1969 INCOMES |
|---------------------------------|-----------------|-----------------|-----------------|
| | Hospital Doctors | General Medical Practitioners | General Dental Practitioners |
| | Age | Appointment | Salary | Average net income | Target average net income |
| | | | | | 1 |
| | 28 | Registrar | 1,790 | 2,7052 | |
| | 29 | " | 1,900 | | |
| | 30 | " | 2,010 | | |
| | 31 | " | 2,120 | | |
| | 32 | " | 2,220 | | |
| | 33 | Senior Registrar | 2,355 | 3,8403 | 34,560 | 3,590 | 35,900 |
| | 34 | " | 2,490 | | |
| | 35 | " | 2,625 | | |
| | 36 | " | 2,760 | | |
| | 37 | " | 2,760 | | |
| | 28-37 | Total | 23,030 | 37,265 | 35,900 |
| | 38-64 | Full-time | | | |
| | 64 | Consultant: | | | |
| | | (Average net Income)4 | 5,465 | 147,555 | |
| | | | 3,8403 | 103,680 | |
| | | | | 3,590 | 96,930 |
| | 28-64 | Total | 170,585 | 140,945 | 132,830 |

Source unless otherwise stated: Report of the Review Body on Doctors' and Dentists' Remuneration; Cmd 5010 (p. 52) HMSO 1972.
1. See footnote 1 to table 4:7(a).  
2. See note 40 to this chapter.  
3. See footnote 3 to table 4:7(a).  
4. Average annual net income (including income from Distinction Awards) for all ages. Income of consultants under 33 is probably lower, and of consultants over 64 higher, than the average. As the numbers in these age groups is small, the effect on average income is probably limited.
Both these comparisons suffer from the fact that earnings by age groups were not available for general practitioners. Comparisons therefore had to be made in terms of the average net incomes for doctors and dentists of all ages and thus (a) underestimate the excess of the general practitioner's earnings over the hospital doctor's during the early stages of the life-cycle and (b) underestimate his deficit in the later stages of the life-cycle since his earnings reach their peak between ages 35-44 and then drop.29

In Table 4:8 (a) an attempt is made to take private practice earnings into account. Data on incomes by age groups is available for incomes from all sources and we are thus able to get a more reliable estimate of the excess of general medical and dental practitioners' incomes over hospital doctors' incomes during the early stages of the life-cycle. This excess is now shown to be considerably greater than the earlier comparisons suggested it might be. However, as the private practice earnings of consultants is considerably greater than that of general practitioners, the total career earnings of hospital doctors is now shown to be considerably greater than those of both general medical and dental practitioners.

The value of these comparisons is related to the accuracy of the data. The all sources income for consultants and general practitioners is derived from an Inland Revenue Inquiry undertaken for the Halsbury Review Body. But the incomes offered young entrants to general medical practice in advertisements in the medical press appear to suggest that the Review Body underestimates the incomes of general medical practitioners. Figures supplied to me by the Personal Services Bureau
TABLE 4.8  CAREER EARNINGS OF HOSPITAL DOCTORS AND GENERAL MEDICAL AND DENTAL PRACTITIONERS FROM ALL SOURCES ON THE BASIS OF 1969 INCOMES

<table>
<thead>
<tr>
<th>Age</th>
<th>Appointment</th>
<th>Hospital Doctors</th>
<th>General Medical Practitioners</th>
<th>General Dental Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Average net income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Registrar</td>
<td>1,790</td>
<td>2,705</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>&quot;</td>
<td>1,900</td>
<td>3,571</td>
<td>8,840</td>
</tr>
<tr>
<td>30</td>
<td>&quot;</td>
<td>2,010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>&quot;</td>
<td>2,120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>&quot;</td>
<td>2,220</td>
<td>4,018</td>
<td>22,100</td>
</tr>
<tr>
<td>33</td>
<td>Senior Registrar</td>
<td>2,335</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>&quot;</td>
<td>2,490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>&quot;</td>
<td>2,625</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>&quot;</td>
<td>2,760</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>&quot;</td>
<td>2,760</td>
<td>4,114</td>
<td>13,791</td>
</tr>
<tr>
<td>28-37 Total</td>
<td>23,030</td>
<td>39,668</td>
<td>44,731</td>
<td></td>
</tr>
<tr>
<td>38-</td>
<td>Full-time/Part-time Consultants</td>
<td>4,636</td>
<td>9,372</td>
<td>4,414</td>
</tr>
<tr>
<td>39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-</td>
<td></td>
<td>5,692</td>
<td>28,160</td>
<td>4,487</td>
</tr>
<tr>
<td>44</td>
<td></td>
<td>6,476</td>
<td>64,760</td>
<td>4,479</td>
</tr>
<tr>
<td>45-</td>
<td></td>
<td>6,306</td>
<td>68,060</td>
<td>4,124</td>
</tr>
<tr>
<td>54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38-64 Total</td>
<td>176,652</td>
<td>117,793</td>
<td>96,934</td>
<td></td>
</tr>
<tr>
<td>28-64 Total</td>
<td>193,682</td>
<td>157,001</td>
<td>141,665</td>
<td></td>
</tr>
</tbody>
</table>


1. See note 40 to this chapter
2. Average of advertised incomes for the first year of a partnership. This figure is used since the Review Body's 1972 Report does not give income for doctors in this age group.
3. Extrapolated from the average net income for the age group 30-34, since the Review Body's 1972 Report does not give incomes for dentists under 30.
4. Earnings are average net incomes for different age groups. Earnings shown for doctors aged 38 and 39 are average net earnings for the age group 35-39. This may understate consultant earnings at 38/39 since the average for the 35-39 group may have been 'reduced' by the lower earning of younger men. However, there are not many consultants under 38.
of the B.M.A. suggest that in 1969 young entrants to general medical practice were being offered on average £2,705 during a probationary period as assistants (a period of 3-6 months), £3,971 on substantive appointment and £4,944 on achieving parity (time taken to reach parity being about 3 years). This discrepancy between incomes offered in advertisements and incomes reported to the Inland Revenue is difficult to account for. It may be that advertised incomes are unrepresentative in that practices with vacancies tend to be thriving practices. Even so, there is no reason to suppose that only thriving practices require recruits and indeed the wide variation in incomes offered suggests that they were not all affluent practices. On the other hand, it may be that incomes reported to the Inland Revenue understate income levels by overstating expenses.

For what it is worth, Table 4.3 (b) compares the incomes of junior hospital doctors and consultants from all sources with the advertised incomes of general medical practitioners. When this is done, the excess of the hospital doctor's life-time income over the general medical practitioner's is shown to be negligible.

It must be noted that any comparison of life-time earnings is an approximate comparison. Firstly, the range of incomes is wide. The average earnings of consultants are particularly likely to be distorted by the high earnings of a relatively small percentage of men who are in receipt of A Awards and/or large private practice earnings. Secondly, the basic income of general medical practitioners is effectively increased
### Table 4:8  Career Earnings of Hospital Doctors and General Medical Practitioners from All Sources on the Basis of 1969 Incomes

<table>
<thead>
<tr>
<th>Age</th>
<th>Appointment</th>
<th>Salary</th>
<th>Average Advertised net incomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Registrar</td>
<td>1,790</td>
<td>2,705</td>
</tr>
<tr>
<td>29</td>
<td>&quot;</td>
<td>1,900</td>
<td>2,571</td>
</tr>
<tr>
<td>30</td>
<td>&quot;</td>
<td>2,010</td>
<td>2,571</td>
</tr>
<tr>
<td>31</td>
<td>&quot;</td>
<td>2,120</td>
<td>4,944</td>
</tr>
<tr>
<td>32</td>
<td>&quot;</td>
<td>2,220</td>
<td>4,944</td>
</tr>
<tr>
<td>33</td>
<td>Senior Registrar</td>
<td>2,355</td>
<td>4,944</td>
</tr>
<tr>
<td>34</td>
<td>&quot;</td>
<td>2,490</td>
<td>4,944</td>
</tr>
<tr>
<td>35</td>
<td>&quot;</td>
<td>2,625</td>
<td>4,944</td>
</tr>
<tr>
<td>36</td>
<td>&quot;</td>
<td>2,760</td>
<td>4,944</td>
</tr>
<tr>
<td>37</td>
<td>&quot;</td>
<td>2,760</td>
<td>4,944</td>
</tr>
<tr>
<td>28-37</td>
<td>Total</td>
<td>23,030</td>
<td>44,455</td>
</tr>
<tr>
<td>38</td>
<td>Full-time/Part-time Consultant (Average net income)</td>
<td>4,686</td>
<td>4,944</td>
</tr>
<tr>
<td>39</td>
<td>&quot;</td>
<td>4,686</td>
<td>4,944</td>
</tr>
<tr>
<td>40-</td>
<td>&quot;</td>
<td>5,692</td>
<td>4,944</td>
</tr>
<tr>
<td>44</td>
<td>&quot;</td>
<td>28,460</td>
<td>123,600</td>
</tr>
<tr>
<td>45-</td>
<td>&quot;</td>
<td>6,476</td>
<td>4,944</td>
</tr>
<tr>
<td>54</td>
<td>&quot;</td>
<td>64,760</td>
<td></td>
</tr>
<tr>
<td>55-</td>
<td>&quot;</td>
<td>6,306</td>
<td>68,060</td>
</tr>
<tr>
<td>64</td>
<td>&quot;</td>
<td>68,060</td>
<td></td>
</tr>
<tr>
<td>38-64</td>
<td>Total</td>
<td>170,652</td>
<td>133,483</td>
</tr>
<tr>
<td>28-64</td>
<td>Total</td>
<td>193,682</td>
<td>177,943</td>
</tr>
</tbody>
</table>


1. See note 40 to this chapter.
2. This figure has been used since I have no data for earnings in the second year of substantive appointment. Since earnings are usually higher in the second year than in the first, this is an underestimate.
3. See footnote 4 to table 4:8(a).
by the fact that items like a car or a telephone may be treated as practice expenses. This is to the hospital doctor's disadvantage. Thirdly, the effect of different earning patterns on income tax must be taken into account.

In summary

In summary, we may say that the young doctor or dentist who enters general practice is, unlike the young doctor who enters hospital medicine, entering an occupational milieu which is favourable to the performance of breadwinning functions for the family. Firstly, general medical and dental practitioners enjoy job security, whereas hospital doctors are caught up in a competitive struggle for consultant status the outcome of which is uncertain. Secondly, the general practitioner's earning power is at its highest at the period in the family life-cycle when expenditure is at its greatest - in the home-making and family-building phase. The phasing of his rewards from the occupational system is, in effect, in step with the pattern of consumption demands in the family, whereas the hospital doctor's is not. His income is greatest when family consumption demands are at their lowest, in the family dispersal stage of the life-cycle. His total career earnings may be in excess of the general practitioners but they are not substantially so.

IMPLICATIONS FOR FAMILY LIFE

The foregoing analysis of the occupational situations pertaining to hospital medicine and general practice has shown that during the family-building stage of the life-cycle junior hospital doctors
experience a low income and uncertain future while general dental practitioners (like general medical practitioners) experience high and secure incomes and a certain future. The consequences for family life of differences in earning power during this phase of the life-cycle is indicated by the fact that while junior hospital doctors' wives characteristically describe themselves as 'getting by', or 'scraping along', general dental practitioners' wives usually say that they are 'comfortably off', 'have most of the things we need', and are 'happy with what we have'. Because earning power is at its highest in the early stages of their careers, dentists and their families can, as one dentist's wife put it, 'have lots of things when you are young which other people have had to wait a long time for'.

As many as 55% (Table 4:9) of doctors' wives said that they were chronically short of money for everyday household expenditure - that they must 'pinch and scrape' and 'lead a hand-to-mouth existence' to make ends meet. In these households every penny is carefully counted and every item of expenditure carefully considered. Any untoward occurrence creates a major financial crisis and 'shopping sprees' cannot be indulged in. Respondents talked of economising on clothing by buying second-hand clothes for the children and by home dressmaking, of economising on Christmas and birthday presents by hunting them down in second-hand 'antique' shops, and of economising on food by buying cheap cuts of meat and making stews or casseroles, by resorting to sausages and black puddings, and by cut-price buying. At the same time, 21% of doctors described themselves as being 'chronically in debt', 'mortgaged up to the hilt', 'forced to incur overdrafts'. One doctor reported having been on the dole between jobs, and another
TABLE 4:9  CONSUMER ASPIRATIONS OF THE WIVES OF JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS

<table>
<thead>
<tr>
<th>Desired Items of Consumer Expenditure</th>
<th>Doctors' Wives (n = 38)</th>
<th>Dentists' Wives (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improvement in housing situation</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>2. Improvements in/additions to furniture/household equipment</td>
<td>32</td>
<td>19</td>
</tr>
<tr>
<td>3. Own car</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>4. Better holidays</td>
<td>39</td>
<td>6</td>
</tr>
<tr>
<td>5. More active social life</td>
<td>34</td>
<td>-</td>
</tr>
<tr>
<td>6. Larger house-keeping allowance</td>
<td>55</td>
<td>6</td>
</tr>
</tbody>
</table>

Since some respondents named more than one desired consumer item, total % is more than 100%

said that he had come before the courts for non-payment of bills, an indignity which he felt sure no G.P. had ever been obliged to suffer.

By comparison, 69% of dentists' wives explicitly stated that they were satisfied with their standard of living. Only one dentist's wife spoke of difficulties in budgeting for daily household expenditure. Her husband had moved from one practice to another three times (as a result, in part, of 'differences of opinion' with his colleagues) and was now in the process of building up two practices of his own. Both practices were 'run-down' when acquired. The first was acquired three years before the interview, and the second one year before the interview. This couple had been married for a year.
Dentists' wives also only very infrequently expressed a desire for improvements in furnishings and household equipment, for 'better holidays' or for a more lavish social life. By contrast, about a third of doctors' wives desire improvements in furnishings and household equipment, better holidays and a more lavish social life. These wives reported 'making-do' with second hand furniture bought at auction sales and relatives' cast-off furniture, and forswearing labour-saving devices and central heating. Their holidays generally take the form of a visit to parents.

Just over a third of both dentists' and doctors' wives feel that their housing standards are compromised in terms of housing type, size, comfort, neighbourhood location or in the possession of a garden. Nine doctors and their families were in fact living in flats and two in rented accommodation at the time of the interview. Among dentists, house and surgery were combined in five cases. In a further three cases, the family were living in flats.

It is, on first consideration, a little surprising that, given their straightened circumstances, a larger proportion of doctors' wives do not feel their housing standards to be compromised. Two factors may help to explain this. Firstly, in our society the semi-detached suburban house is a symbol of middle-class status. Given this, it is probable that hospital doctors and their wives put the major portion of their resources into the purchase of this desired symbol of middle-class status. Secondly, and perhaps because it is a symbol of middle-class status, the purchase of a house is frequently facilitated by parental help.
The deprivations experienced by hospital doctors and their families are not peculiar to hospital doctors: they are the common experiences of all those on low salaries. But poverty is relative. It is to be measured in terms of the disjunction between income and desired consumption patterns as these are shaped by reference groups. Hospital doctors and their wives, when they compare their standard of living with that of friends and acquaintances in their reference groups – professional and senior managerial groups in general, and general practitioners and American colleagues in particular – feel that they are 'falling behind'. As one doctor put it:

As a doctor you are in Social Class 1 but in terms of salary you have no right to be there. You are expected to keep up a certain standard of living but you have not the facilities to do it with.

This is a situation in which wives are envious of general practitioner friends who qualified at the same time as their husbands but who see to them to be 'living in the lap of luxury'. Among my respondents, one hospital doctor's wife, who after nine years of marriage was still wearing clothes that were part of her trousseau, spoke enviously of the G.P.'s wife who has 40 pairs of shoes, another enviously compared her tenement flat with the 'lovely house' of a G.P. friend, and another spoke of her embarrassment when a G.P.'s wife offered her cast-off maternity clothes, an offer which made her feel that she 'looked shabby'.
ATTITUDES TO EARNING POWER

1. Attitudes of Junior Hospital Doctors

The foregoing discussion has shown that, by virtue of the differences in the opportunity structures pertaining to their different occupational situations, hospital doctors - unlike general dental practitioners - experience severe financial difficulties during the family-building stage of the life-cycle.

However, the junior hospital doctor's earning power cannot be attributed solely to the occupational situation in which he finds himself. For the young hospital doctor chooses to go into medicine rather than general practice. In doing so, he rejects the job security and the comfortable standard of living that is to be enjoyed at all periods of the life-cycle in general practice. Thus, he finds himself in a particular financial situation by virtue of a particular decision. In making this decision, he may hope that he will be one of those hospital doctors whose earnings will eventually be great. But, given the intense competitiveness of hospital medicine, he can be by no means certain that he will in fact be among the big earners. And even if he is, his earning power will be strong at a stage in the life-cycle when his children are leaving home.

The decision to enter hospital medicine rather than general practice is to be explained by an attitude to work in which material interests are held to be less important than intrinsic satisfactions. This is abundantly clear from the reasons given for entering the hospital service (Table 4.10) which show that hospital doctors enter the hospital
### TABLE 4:10  REASONS GIVEN BY JUNIOR HOSPITAL DOCTORS FOR ENTERING THE HOSPITAL SERVICE

<table>
<thead>
<tr>
<th>Class of Reason</th>
<th>Percentage Mentioning (n = 33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Reasons relating to intrinsic rewards:</td>
<td></td>
</tr>
<tr>
<td>Negative:</td>
<td></td>
</tr>
<tr>
<td>Stultifying nature of G.P.</td>
<td>53</td>
</tr>
<tr>
<td>Avoidance of direct contact with the patient</td>
<td>3</td>
</tr>
<tr>
<td>Unhappy experience of collaboration with other doctors in general practice</td>
<td>11</td>
</tr>
<tr>
<td>Positive:</td>
<td></td>
</tr>
<tr>
<td>Greater opportunity for the use of general or specific medical skills</td>
<td>42</td>
</tr>
<tr>
<td>Research/academic environment</td>
<td>16</td>
</tr>
<tr>
<td>B. Reasons relating to extrinsic rewards:</td>
<td></td>
</tr>
<tr>
<td>Conditions of work (e.g. the prospect of being called out in the middle of the night at 55)</td>
<td>16</td>
</tr>
<tr>
<td>Prestige of hospital medicine</td>
<td>3</td>
</tr>
<tr>
<td>C. No information:</td>
<td>3</td>
</tr>
</tbody>
</table>

% giving an extrinsic reason: 21
% giving only extrinsic reasons: 5
% giving intrinsic reasons: 92
% giving only intrinsic reasons: 76

Since some respondents gave more than one reason for entering hospital medicine, total % is more than 100%
service because they believe that self-fulfilment and work satisfaction is to be found in hospital medicine but not in general practice."^27

Most of the men in the sample define general practice as stultifying, the general practitioner as little more than a high class vet or shop-keeper, and his patients as 'shifters wanting to be off work' or 'neurotic housewives with too little to do'. They see the general practitioner as spending his days dealing with 'trivia', and 'petty complaints', 'jessing along people with nothing wrong with them', and filling in forms required by a bureaucratic society. So, burdened by paper work and plagued by queues of 'shifters' and 'neurotic housewives', the general practitioner has not the time or energy to deal with any real problems that may turn up on his doorstep. And even if he did, he would not have the training or the facilities to deal with serious cases. Hence he can only send them on to the hospital doctor.

In these circumstances, general practice becomes, in the view of hospital doctors, a sorting station, and the general practitioner does a superficial job which does not utilize his training, his knowledge or his abilities. In the isolation of general practice his 'knowledge drops off dramatically; he is 'lost, slipping, forgetting'. Further, the general practitioner is at the beck and call of 'moronic patients' all his life - of patients who have little respect or consideration for their general practitioner, who regard him as their servant, as being little better than the milkman, and so regarding him, summon him out for trivia even at 4.00 in the morning on a cold winter's night.
In the words of one respondent, 'Even kings of avarice like me sometimes say this is something I would not like to do and do not do it despite the money. It would be suppressing your personality - horrendous really.'

Hospital medicine, on the other hand, is defined as providing the environment appropriate to the practice of 'real medicine'. It provides the opportunity for the development and application of general or specific medical skills - the craftsmanship of the surgeon, the 'life-giving' skills of the obstetrician, the diagnostic skills of the physician, the clinical expertise of the pathologist. It is in hospital that 'interesting' medical problems are investigated and treated and other stimulating medical men are encountered. There are opportunities for teaching and research, experimentation, discovery and the furtherance of medical knowledge. Hospital medicine is 'high-powered', 'challenging', 'stimulating', 'creative'. The following extracts from the interview schedules illustrate the central importance of intrinsic work satisfaction to the hospital doctor.

Case No. 9:
It is awfully difficult to explain. Obviously I would like to have a yacht or two cars. But I wouldn't be disappointed at not having these things.

The thing is in medicine I would have these things if I were to emigrate or become a general practitioner. But the things I would have to sacrifice would not be worth it. If I were to emigrate, we would both miss our families. My father was at sea most of the time I was growing up and it is only since he has retired that I have got to know him. And I would regret not reaching the top. If I emigrated, it would mean that I would not be able to achieve my ambitions and that would aggravate me.

General practice is a bad form of medicine and if I were to go into general practice I would feel that I had devoted six/seven years to becoming an expert and would have no use for this expertise in general practice. Also I have done general
practice locums - and they drive you to distraction because there are so many petty trivial things you have to do. The general practitioner has become a servant to his own patients.

Case No. 1: Work is important to me because I enjoy it, not for the money I get out of it. Or the status, though we do fancy ourselves a bit. We like to impress people.

Case No. 10: I'd rather be paid my salary and enjoy what I am doing than be paid a lot more and be bitter and twisted and fed up.

The attitudes here revealed tally with the ratings given to various rewards of work. As reported earlier, only a small percentage of hospital doctors, when asked to say how much importance they attach to various work rewards, say that either income or security is very important, but most say that self-fulfilment is very important. In effect, the decision to enter the hospital service rather than general practice is taken within the context of a set of life-interests in which work is defined primarily as a source of self-fulfilment and self-expression, not as a livelihood. Thus hospital doctors find themselves in a situation in which their earning power presents difficulties for the family, difficulties which could have been avoided if intrinsic satisfactions had been subordinated to material interests. This subordination of material interests seems to be legitimated by the belief that the achievement of self-fulfilment in work is so important a factor in the general happiness of the individual that failure to find satisfaction in work will affect familial and other non-work relationships. As one doctor put it, 'I could double my salary in general practice, but, although I could buy the family a better house, I wouldn't be fit to live with. It would not be worth it.'

Yet the issue is not clear cut for all men. The interview data suggests that for some hospital doctors the assignment of self-
fulfilment in work is paralleled by a puritan disregard for the creature comforts of this world. But others are both 'kings of avarice' and searchers after intrinsic satisfactions.

The material aspirations of hospital doctors in the first group suggest that they do not live lavishly and do not want to do so. In their view their salaries, though not bounteous, are adequate - sufficient for their sober tastes and moderate needs - and their families' living standards are not seen as adversely affected by their decision to enter the hospital service. Thus, the situationally-structured incompatibility between work and family is not experienced as conflicting.

Case No. 8: We feel we have enough to live on. Our tastes are moderate, sober. I would not particularly want an extravagant mansion just because everyone else does. It would give us no pleasure to have a glossy car.

Case No. 23: I do not think we would live very differently if we had more money. Perhaps we would have another car and furnish the house more lavishly - it's largely furnished with relatives' cast offs. But it does not bother us much. Our aspirations are very modest. We are not great socialites. We are not fussed about superb furniture or a spotless house. We do not drink much.

By contrast, hospital doctors in the second group aspire after both self-fulfilment in work and a comfortable life-style. For these men '£10,000 a year would be nice', 'money means a lot', and it would be 'nice' to 'make a lot of money and live in comfort', to have a 'comfortable home' and 'decent holidays', and to be able to 'indulge hobbies' and 'send the children to a good school'. As one doctor put it, 'I've no great aspirations to be a multi-millionaire. I'd not have gone into medicine if I did. But I'd like to have a nice house
and to have enough money to live comfortably.\textsuperscript{53}

In such cases the decision to enter the hospital service seems to represent an ordering of priorities in which job satisfaction is given precedence over income rewards but in which income rewards are nevertheless defined as desirable. In effect, aspirations clash. It is in such circumstances that the situationally-structured conflict between work and family seems to be experienced as conflicting.

Conditions of service—income levels, insecurity of tenure of office, length of apprenticeship to consultant status, the intensity of competition for position and the haphazard nature of training programmes—are experienced as frustrating.\textsuperscript{54} My data suggests that these men tend to see the general practitioner as enjoying unfair advantages, the government as taking advantage of the fact that 'you have a satisfying job and you do not want to leave it', and the B.M.A. as a 'union' concerned to further the interests of G.Ps. at their expense.

The relationships between material aspirations and discontent with conditions of service is clearly demonstrated in Table 4:11. Discontent with conditions of work is always voiced by those men who regard as very important both income as a reward of work and their breadwinning functions as an aspect of a husband's role.

At the same time discontent with the rewards of work is rarely voiced by those men who attach relatively little importance to income as a reward of work and to the breadwinning function as an aspect of a husband's role.

The clash of aspirations and the tension to which this clash gives rise may be illustrated by extracts from the interview schedules.
TABLE 4:11  RELATIONSHIP BETWEEN IMPORTANCE ATTACHED TO INCOME AS A REWARD OF WORK/BREADWINNING ASPECT OF THE HUSBAND- ROLE AND DISCONTENT WITH REWARDS OF WORK

<table>
<thead>
<tr>
<th>Importance Allocated to Income and to Breadwinning Function</th>
<th>Frustration Expressed</th>
<th>Frustration not Expressed</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>Breadwinning functions and income scored 1</td>
<td>100</td>
<td>0</td>
<td>100 4</td>
</tr>
<tr>
<td>Breadwinning functions scored 1, 2</td>
<td>41</td>
<td>59</td>
<td>100 22</td>
</tr>
<tr>
<td>Income scored 1, 2, 3/4</td>
<td></td>
<td></td>
<td>41 59</td>
</tr>
<tr>
<td>Breadwinning functions scored 3/4</td>
<td>18</td>
<td>82</td>
<td>100 11</td>
</tr>
<tr>
<td>Income scored 2, 3/4</td>
<td></td>
<td></td>
<td>18 82</td>
</tr>
<tr>
<td>All</td>
<td>41</td>
<td>59</td>
<td>100 37</td>
</tr>
</tbody>
</table>

Note: The combination of a score of 3/4 for breadwinning functions and of 1 for income did not occur

Case No. 9: This is one of the complaints of doctors in hospital - we find it difficult to provide for our families. The real thing that I feel as head of the family is insecurity. Ever since qualifying I have lived in a state of tension that something is going to go wrong that will wipe out the few £s we have in the bank. I would like to have enough money for my wife to shop without having to perpetually be looking at the bank balance. I have never met a G.P.'s wife who had to think about it like this. I would like to be in a situation where we could spend a little more money without worrying about it coming off the gas bill.

Case No. 12: And it was at this time (when a decision had to be made as between general practice and hospital medicine) that the argument came up: was it worth putting up with the lack of cash for the sake of the job - with possibly neglecting children and wife too. But I liked the job and I felt I couldn't enjoy doing general practice for the rest of my life. It was not only that I wouldn't enjoy it - I didn't think I could put up with it. Possibly because there is so little practical work in general practice and (his specialty) is largely a practical sort of job.
Case No. 13: I would like to be able to take the kids out on their birthdays. I would like to be able to buy a new bike. Whereas in fact what I have to do is to go round Edinburgh until I find a second-hand one and then paint it. And.... (his wife) was complaining the other night that she was still wearing clothes she had for her trousseau. (This couple had been married for 9 years). I have been limping along in an old car for a long time and I have just been able to get.... (his wife) a car (an old one) whereas friends of the same age in general practice can afford to change cars regularly, because they get allowances for cars which we do not. I feel very strongly about inequalities of pay. You are getting on to a big subject. For the whole of his life the income of the general practitioner is mostly in excess of a hospital doctor. He has an average income of £5,000. The top salary I could aspire to is £5,000. And many G.P.s make more than that. It is basically wrong. Iniquitous.

Case No. 20: The money problem is the major problem. There is the constant worry of how to pay this debt or that debt, to go out or not to go out, to service the car this week or chance it for another week. These things I find the most annoying things - getting the cash for the ordinary things. I am not bothered about not being able to go to Majorca for holidays. Our tastes have always been moderate. It is always the worry of finding the money for minor things that annoys me most. My wife gets the heavy end of the stick - ask her when last she had a new dress or did her hair. And now I have a backlog of debts and you ask yourself is it worth it? Particularly after seeing the American way of doing things - there after 3 1/2 years of training they are living in the grand manner without worrying about ordinary things.

In sum, the structure of opportunity in general practice is better fitted to family consumption demands than in hospital medicine. Nevertheless, hospital doctors have preferred hospital medicine to general practice. They do so because they believe that intrinsic satisfactions are to be found in hospital medicine but not in general practice. That is to say, they find themselves in a disadvantaged earning power situation by virtue of their occupational values and aspirations.
Given this, the structured incompatibility between their earning power and family consumption needs may not be experienced as conflicting. Whether or not it is experienced as conflicting seems to be related to the importance that is attached to material well-being. Where the assignment of paramount importance to the achievement of self-fulfilment in work is allied with a puritan disregard for the 'creature comforts' of this world, hospital doctors seem contented with their conditions of service. But where a desire for self-fulfilment in work is accompanied by a desire for the 'creature comforts' of this world, then work and family are experienced as conflicting and doctors are discontented with their level of remuneration, the insecurity of their tenure of office and the length of their apprenticeship to consultant status.

2. The attitudes of general dental practitioners

The particular nature of the occupational aspirations and discontents of junior hospital doctors, revealed in the foregoing discussion, is highlighted by a comparison with the aspirations and discontents of general dental practitioners.

General dental practitioners, like hospital doctors, believe that it is very important to find self-fulfilment in work; but, at the same time they, unlike hospital doctors, attach very great importance to income and security rewards. Decisions taken within the context of this orientation to work are more likely to be influenced by extrinsic considerations in decision-making. As Table 4:12 shows, 81 per cent of dentists give instrumental reasons for entering general
practice, whereas only 21% of hospital doctors give instrumental reasons for entering the hospital service.\textsuperscript{57} Further, only 13% of dentists give only intrinsic reasons for entering general practice. This compares with 76% of doctors giving only intrinsic reasons for entering hospital medicine.\textsuperscript{58}

<table>
<thead>
<tr>
<th>Class of Reason</th>
<th>Percentage Mentioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Reasons relating to intrinsic rewards:</td>
<td></td>
</tr>
<tr>
<td>Negative: dislike of hospital dentists career structure</td>
<td>25</td>
</tr>
<tr>
<td>ability felt not to be appropriate for hospital dentistry</td>
<td>19</td>
</tr>
<tr>
<td>Positive: greater scope of general practice</td>
<td>37</td>
</tr>
<tr>
<td>B. Reasons relating to extrinsic rewards:</td>
<td></td>
</tr>
<tr>
<td>income rewards</td>
<td>63</td>
</tr>
<tr>
<td>disinclination for further study</td>
<td>44</td>
</tr>
<tr>
<td>No information</td>
<td>6</td>
</tr>
</tbody>
</table>

\textsuperscript{57} Since some respondents gave more than one reason for entering general practice, total % is more than 100%
This money orientation is reflected in practice procedures. Dentists may seek to increase their income by streamlining practice procedures so as to increase the number of operations performed per hour. Services that are considered 'uneconomic' (such as crowns and bridges) - in that the fees paid do not seem commensurate with the time and effort involved - may not be undertaken under the National Health Service or may be kept to a minimum despite the fact that such services provide satisfactions not to be found in routine work. Dentists argue that to earn a 'good living' they must work at nerve-racking speed and avoid complex and interesting but time-consuming and, therefore, uneconomic dentistry. Yet dentists could work at a more leisurely pace and do the kind of work they find satisfying (if uneconomic) without seriously impairing their income situation if they were not orientated to earning as much as possible within a delimited working week. That they do not do so - and do not see themselves as able to do so - is indicative of their money-orientation to work rather than of methods of payment per se.

The economic rewards which dentists reap from dentistry do, in fact, please them. During the interviews they frequently expressed satisfaction with the size of their incomes and with their standing vis-à-vis other young professional men. Even so, there are dissatisfactions with the reward system. Firstly, there is dissatisfaction with the fact that income, being based on payment for each item of service performed, is disrupted by illness and tends to drop towards the end of their careers when a high pace of work can no longer be maintained. Secondly, financial arrangements with associates, partners, and principals may occasion discontent. In particular,
young men working as assistants to, or associates of, older men tend to feel that financial arrangements do not properly take account of the fact that they can and do work faster than older men and are therefore, in their view, 'lining the pockets' of other men by their endeavours.

It is relevant to note here that general dental practitioners do not appear to find in work the intrinsic satisfactions they would also like to have - and that the gearing of practice procedures to the maximisation of income would seem to be partly responsible for this lack of satisfaction. This is suggested by the frequency with which dentists voice discontents arising from the nature of their work and the organisational context within which it takes place.

As Table 4.1 shows, nearly two-thirds of the sample experience dentistry as 'hard work', involving concentrated and arduous endeavour and physical and nervous strain.

Secondly, 56% of the sample find the content of their work unsatisfying in that it generally consists of routine operations, requiring only minimal technical skills, and the paperwork required by a 'bureaucratic' society, while skilled and interesting dental work is (in their view) ruled out by the system of remuneration and/or a parsimonious Health Department.

Thirdly, patients are regarded as 'trying' by nearly half the sample. They are regarded as trying in that they are nervous and apprehensive, fearful of pain when little or no pain is to be expected with modern methods of dental care; as unpunctual and arrogant in their attitudes to their dentist whom they expect to be at their beck
and call; as careless of their dental health, being less interested in the conservation of their teeth than they ought to be and unwilling to pay for their dental care.

Fourthly, the organisational context of work may be experienced as frustrating. Twenty-five per cent of the sample complained of staffing problems and administrative inefficiencies — of unreliable and inefficient receptionists and chairside assistants — while 19% of the sample expressed resentment of the obligation to obtain governmental approval for certain types of work. In other words, they resented the subordination of professional judgement to bureaucratic rules regarding expenditure.

By contrast, hospital doctors seem to find in work the intrinsic satisfactions they seek. The dissatisfactions they voice are few and seem to centre on organisational factors: lack of independence, petty officialdom, lack of research facilities, staff shortages, administrative inefficiencies (Table 4:13). 64

In summary then, the young man who becomes a general dental practitioner takes on an occupational role that is favourable to the performance of his breadwinning functions in that income rewards are high and secure in the early stages of his career. Further, the assumption of this occupational role takes place within the context of a value system in which considerable importance is attached to the extrinsic rewards of work. Nevertheless, their essentially extrinsic orientation to work is not necessarily accompanied by a philistine disregard for self-fulfilment in work. Dentists also aspire to self-fulfilment in work and, while enjoying the economic fruits of their
### TABLE 4.13 INTRINSIC WORK DISSATISFACTIONS EXPERIENCED BY JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS

<table>
<thead>
<tr>
<th>Source of dissatisfaction</th>
<th>Doctors (n=19)</th>
<th>Dentists (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Times Mentioned</td>
<td>% Mentioning</td>
</tr>
<tr>
<td><strong>A. Nature of Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Hard' work/pace of work</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Skilled work precluded/paperwork</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>'Trying' patients</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unsatisfactory personal performance</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td><strong>B. Organisational Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of independence</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>Staffing problems/administrative inefficiencies</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total number of complaints</strong></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Average number of complaints per individual</strong></td>
<td>.68</td>
<td></td>
</tr>
<tr>
<td>% of sample voicing complaints</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

1. n = 19 as probes for sources of intrinsic dissatisfactions were not made consistently until I was half way through the interviewing. I have therefore included here only that portion of the sample consistently probed.

2. Each category of complaint subsumes different aspects of the same phenomenon and 'times mentioned' refers to the total number of respondents mentioning different aspects of the same complaint category, not to the total number of times each type of complaint was mentioned.
labours, may experience work as unrewarding. By contrast, the young man who becomes a hospital doctor takes on an occupational role that is not favourable to the performance of his breadwinning functions in that income is low and the tenure of office uncertain during the family-building stage of the life-cycle. Further, the assumption of his occupational role takes place within the context of a value system in which great importance is attached to the intrinsic rewards of work. Nevertheless, some hospital doctors also aspire to material well-being and consequently, though enjoying their work, experience their conditions of service as frustrating. Their material aspirations and their work aspirations are disconsonant.

3. The attitudes of wives to their husbands' earning power

The wives of junior hospital doctors seem to regard as legitimate the subordination of material interests to the achievement of self-fulfilment in work. As I have already shown, only 18% of doctors' wives regard the breadwinning aspect of a husband's role as very important and as many as 47% regard it as only fairly important or as of little importance. Further, the modal wife regards a good income as an important rather than a very important reward of work. Security is somewhat more frequently regarded highly, but status is very generally little regarded. At the same time 92% of doctors' wives believe self-fulfilment in work to be very important.

Attitudes revealed during interviews show that these responses are not merely conventional responses invited by structured questions. Wives' discussions of their 'aims in life' suggest that their material
aspirations are relatively modest. 'Money,' I was told, 'is not all that important.' Some wives explicitly denied having 'expensive tastes' and 'grand aspirations'.

But it is not only that wives' material aspirations are relatively modest. Wives seem genuinely to believe that fulfilment in work is essential to a man's happiness and that a man's happiness is essential to the happiness of the family. Thus, the typical doctor's wife believes that it is important that her husband should 'do the job he wants to do', that he should do what he wants to do even if it means that 'we do not get as much as we need'. If her husband is 'happy in hospital medicine', then she is 'happy for him', and is prepared to do with less. The relative affluence of general practice is not considered to be worth the cost, an unfulfilled and frustrated husband for 'when it comes down to it, you have got to live with him'. In two instances, husbands wavering between the joys of hospital medicine and the financial attractions of general practice were in fact helped to make the decision to remain in the hospital service by the encouragement given them by their wives.

Thus is the subordination of material interests to the achievement of intrinsic satisfaction in work legitimated, and the structured incompatibility, which exists between work and family life in terms of the discontinuity between the pattern of economic rewards in the occupational system and the pattern of consumption demands in the family system resolved.

This attitude towards the maximisation of income rewards is, up to a point, shared by the wives of general dental practitioners.
Dentists' wives, as I have shown, do tend to value more highly than doctors' wives the breadwinning role of husbands and the economic rewards of work. They are at the same time in a relatively affluent situation and are satisfied with their living standards.

On the other hand their material aspirations are sometimes more modest than the dentists' material aspirations (as judged by their differential valuation of the income rewards of work and the breadwinning role).

Further, and more importantly, some wives expressed the view during the course of the interviews that the pace at which their husbands worked in order to increase their incomes was not worth the cost in terms of the expenditure of nervous energy and the dissatisfactions produced.

STRATEGIES FOR REDUCING THE GAP BETWEEN INCOME AND CONSUMPTION PATTERNS

Junior hospital doctors may have found themselves in an occupational situation which is unfavourable to the performance of their breadwinning functions by virtue of their subordination of material interests to intrinsic work satisfactions, and this ordering of priorities may be endorsed by their wives. But hospital doctors do at the same time adopt various strategies to reduce the gap between income and desired consumption patterns. These strategies may be identified and categorised as follows:

A. Individual Strategies: Action taken on an individual basis for supplementing income.

B. Evasive Strategies: Action aimed at circumventing the problem.

Evasive strategies are also individualised responses to the income earning situation, but strategies in the first category
attempt to work within the situation, whereas evasive strategies represent attempts to avoid the situation.

C. Collective strategies: Action taken by junior hospital doctors acting in concert to better their income-earning situation. Such action is aimed at modifying the occupational structure.

A. Individual strategies

Junior hospital doctors may, acting as individuals, seek to supplement their income in three ways.

Firstly, they may supplement their salaries by doing G.P. locums in the evenings, at weekends or during their holidays; by working for the blood transfusion service; by lecturing to nurses, first aid groups, or graduate students; or by doing medical insurance reports. This is how one doctor described the strategies by which he attempted to supplement his salary:

Case No. 6: I have done a lot of locums. It cost £30 to take the exams. I earned the money in dribbles and drabbles of £3 for an evening’s locum here and £15 for a weekend’s locum there when on off-duty, and in 3 long locums in my annual holidays... living on my own in boarding houses... that’s the N.H.S. for you... I did one whole locum (in a holiday) just to earn enough money to buy...(his wife) a washing machine.

Secondly, incomes may be supplemented by wives’ earnings. Three wives in my sample reported working after the birth of their first child for financial reasons.

Thirdly, incomes may be supplemented by parental help or by independent means. Twenty couples in the sample reported receiving parental help or having independent means.
Assistance with the purchase of a house (usually in the form of paying the deposit) is the most important contribution made by parents to the resources of the family. It is perhaps only in this way that some hospital doctors and their families are able to achieve early in their careers this basic element of the middle-class style of life. Holidays, either spent gratis with parents or paid for by parents, are also frequently achieved only by means of parental aid. Parents may enhance living standards by means of substantial presents, given on socially approved occasions such as the birth of a baby, christenings, birthdays and at Christmas. Presents on such occasions may include labour-saving devices for the home, 'luxuries' the family could not otherwise afford (such as a second car), or status-giving props. Parents may also finance private education, generally perceived by the middle class to be essential in the context of the Edinburgh education system.

Aid received from parents helps hospital doctors and their families to maintain the style of life considered appropriate to middle-class status. It is difficult to determine the extent to which the standard of living of the hospital doctor and his family is raised in this way as it was not possible to collect information systematically and uniformly in so sensitive an area. But some respondents stated categorically that, if it had not been for parental aid, they would be 'bankrupt', 'right under', would find it 'very rough', would have 'been unable to buy a house', would have 'emigrated long ago'. These findings support Bell's contention that parental aid in the middle class is not, as Sussman and Burchinal suggest, simply invoked 'when member families are in personal difficulties or
in times of disaster and crisis and on ceremonial occasions, but rather is given continuously and operates fairly systematically to maintain the social status of the family by raising living standards.

B. Evasive strategies

Medical emigration - which during the 1960s resulted in an annual net loss of between 330-450 British born and trained doctors, or about one-fifth of the total output of British medical schools - represents an attempt to evade the perceived problem of achieving both intrinsic and extrinsic satisfactions in the British medical system.

As work on medical emigration suggests, emigrating doctors leave Britain to avoid frustrating conditions of work and, in doing so, hope to find greater opportunities for realising both intrinsic and extrinsic aspirations. Reasons given by emigrating doctors for leaving Britain include:

1. a desire for better opportunities for teaching and research;
2. dissatisfaction with career prospects in the hospital service;
3. financial gain;
4. dissatisfaction with the role and scope of general practice and, in particular with the dissociation of general practice from the work, resources and privileges of the hospital service;
5. curiosity and restlessness.

Both the importance of emigration as an evasive strategy among doctors and the relative satisfaction of dentists with their conditions...
of work are indicated by the fact that emigration among dentists is low. 30

C. Collective strategies

Junior hospital doctors may also seek to improve their conditions of service and remuneration by collective action; they have done so with increasing vigour in the last few years. The formation of the Junior Hospital Doctors' Association and the retention fee issue is evidence of their increasing recourse to collective action.

Traditionally, collective strategies have been articulated through the British Medical Association. As a professional association, the B.M.A. is charged with the function of presenting the junior hospital doctors' case for changes in terms and conditions of service to the Departments of Health and to the Standing Review Body on Doctors' and Dentists' Remuneration. 31

Recently, however, hospital doctors have come to feel that the B.M.A. is so structured as to result in the subordination of their interests to those of general practitioners and consultants in that proposals from the Hospital Junior Staffs Group Council (the H.J.S.G.C.) may be vetoed by the Central Committee for Hospital Medical Services (the C.C.H.M.S.) on which junior hospital doctors are not adequately represented. This feeling led to the formation in 1966 of the J.H.D.A. 32 with the avowed objective of securing 'proper representation' for junior hospital doctors either within the B.M.A. or independently of the B.M.A. so that their interests might be forcefully articulated in the corridors of power.
The J.H.D.A.'s objectives, as outlined in their 1972 policy document, include:

1. radical reform of the hospital career structure so as to obtain security of tenure and better opportunities for advancement through the expansion of the consultant grade;

2. limitation of hours of work;

3. improvements in accommodation for compulsorily resident doctors;

4. adequate ancillary help so that doctors may be freed from routine clerical work;

5. a more rigorous system of postgraduate-training supervision which would make consultant responsibility for the training of junior staff 'actual rather than theoretical';

6. representation for junior doctors on the various committees and boards responsible for hospital administration.

The J.H.D.A. has sought to achieve these objectives by means of an active publicity campaign. It has garnered information and statistics on the working conditions, living accommodation and postgraduate training available for doctors. The first of such surveys was carried out in the Liverpool region and the report was published
under the title 'For Services Rendered'. Similar surveys have been conducted in the Sheffield and S.W. Metropolitan regions.

The well publicised retention fee issue also represents a protest against, and an attempt to improve, their career position. Junior hospital doctors feel that the way in which the General Medical Council performs its functions (in terms of registration, discipline and the guidance of postgraduate education) is out-of-date and, secondly, that they are inadequately represented on and by the Council. Hence their protest against the payment of annual retention fees.

Largely as a result of J.H.D.A. activity, junior hospital doctors have been successful in obtaining a moratorium on the unpopular Medical Assistant Grade and the introduction of a system of overtime payments for on call duty in excess of 102 hours per week.

Further, J.H.D.A. activity has pressurised the B.M.A. into granting the H.J.S.G.C. autonomy for a year and thus power to negotiate directly with the Departments of Health on conditions of work. In November 1973 this group began negotiations with the Departments of Health on a new standard contract, to be binding on all hospital-employing authorities, aimed at securing, inter alia, a reduction in hours of work, action on hospitals where residential accommodation is below standard, and more extensive study leave. But thus far little has been achieved in the way of improving opportunities of advancement.

The adoption of collective strategies to achieve greater and more secure earning power represents an attempt by hospital doctors to modify their occupational situation so that it should be more
compatible with their family situation. Recourse to this kind of action is symptomatic of the conflict (described earlier) which exists for some hospital doctors between their desire to find intrinsic satisfaction in work and their desire for high living standards. As I have shown, hospital doctors are not denied high living standards in the early phase of their life cycle simply by virtue of the structure of opportunity pertaining to their work situation: they have in fact chosen to enter that situation rather than another and more economically rewarding situation (that of general practice) so that they may work in a branch of medicine which they believe they will find intrinsically rewarding. Nevertheless, some doctors desire high consumer power and find their conditions of service frustrating. Collective action is an attempt to realise their extrinsic aspirations by modifying the structure of opportunity that pertains to their occupational situation whilst working in an area of medicine in which their intrinsic satisfactions are being fulfilled.

POSTSCRIPT: THE BALANCING OF INTRINSIC AND EXTRINSIC REWARDS

My findings suggest that the distinction customarily made between intrinsic/extrinsic orientations to work must be modified in that men do not necessarily have either an intrinsic or an extrinsic orientation to work — some men are clearly desirous of maximising both intrinsic and extrinsic orientations to work. This is suggested by the fact that:

a) some hospital doctors and many general dental practitioners regard as very important both the opportunity for self-fulfilment in work and income and security rewards;
b) both intrinsic and extrinsic considerations may influence career decision-making;

(c) men (as in the case of some hospital doctors) may enter a particular occupational situation for the sake of the intrinsic satisfactions it is expected to provide but may then seek to modify that situation so as to better the extrinsic rewards to be derived therefrom.

These findings are not altogether surprising for, as I suggested earlier, middle-class men work in situations, and are exposed to expectations which tend to induce both intrinsic and extrinsic orientations to work. They are, on the one hand, exposed to generalised cultural expectations of occupational 'success'. Further, their occupational situation encourages an achievement orientation by virtue of the way in which rewards are structured - and this applies both to hierarchic structures and to the situation of the independent professional and entrepreneur. On the other hand, the middle-class worker may be encapsulated within a professional culture in which work is normatively defined as a 'central life interest'. Further, and paradoxically, self-fulfilment may be found in the achievement of extrinsic rewards since, in middle-class occupations, the maximisation of extrinsic rewards is generally dependent on personal achievement and a sense of personal achievement is in itself satisfying.

Where the maximisation of both intrinsic and extrinsic rewards is desired, and where both cannot be achieved by the same career path, then aspirations clash and career decision-making involves the delicate balancing of one set of rewards against the other. Here what is
important is the level of intrinsic/extrinsic satisfactions to be derived from the particular job under consideration. For example, below a certain income level priority may be given to material rewards while above it priorities may be reversed. This may be illustrated by the comments of one respondent. He said, 'I wouldn't take a job I didn't think I would enjoy for the sake of a slightly higher salary. But if you are scraping the barrel, you have got to get money.'

The ambivalence which may be created by the desire for both material rewards and job satisfaction may be illustrated by the contradictory statements of two doctors.

Case No. 10: (My main aim in life is) 'To get a job which satisfies me and at the same time brings in enough £sd for the family.' Probed as to which he regarded as more important, job satisfaction or £sd, he said: 'It's got to be £sd, otherwise the family could not exist. You work for one reason only and that's to have a relatively happy life. It so happens that my job is particularly interesting.' But in the next breath, he insists on the importance of job satisfaction: 'If I weren't happy in medicine I would change. The happiness of any family centres round both parents and if one is decidedly unhappy you have to change.'

Case No. 14: 'One's professional aims you always tend to place first. I think one's aims become higher on being married because you have more to gain by them. So one's family really comes prior to them.' But in the next breath he says: 'I would like to bring up my family in the way I was brought up. But I couldn't afford to do so. I could in theory become a G.P. and double my salary. But one has professional aims. So one compromises all the time.'
CHAPTER V

The Problem of Geographical Mobility

MOBILITY EXPERIENCES

Geographical mobility is much higher among junior hospital doctors than among general dental practitioners. As Table 5:1 shows, 50% of dentists, compared with 18% of hospital doctors, have not experienced any mobility since graduation. Since marriage 69% of dentists, compared with 24% of hospital doctors, have not been mobile. 1

Moreover, geographical mobility among dentists takes place within a limited geographical area. All those dentists who experienced mobility after marriage moved within the Lothians or between neighbouring Fifeshire and the Lothians. By contrast, only 3 of the 29 doctors experiencing mobility since marriage moved within the Lothians or between Fifeshire and the Lothians. Eight hospital doctors and their wives moved between the Lothians and other parts of Scotland, while 18 moved between England and Scotland or between America and Scotland.

As a corollary of their more limited geographical mobility, both dentists and their wives are more likely than hospital doctors and their wives to be natives 2 of Edinburgh and/or the Lothians (Table 5:2).

Similarly, 94% of dentists but only 53% of hospital doctors are graduates of Edinburgh University. The remainder of the dentists (6%) and 13% of the hospital doctors are graduates of other Scottish universities. Thirteen per cent of the doctors are graduates of London teaching hospitals. The remainder are from hospitals in various parts of England.
<table>
<thead>
<tr>
<th>Rate of Mobility</th>
<th>Since Graduation</th>
<th>Since Marriage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctors</td>
<td>Dentists</td>
</tr>
<tr>
<td>1. Once in every year or more frequently</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>2. Less frequently than once a year but at least once in every 2 years</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>3. Less frequently than once in every 2 years but at least once in every 3 years</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>4. Less frequently than once in every 3 years but at least once in every 4 years</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>5. Less frequently than once in every 4 years</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>6. No mobility</td>
<td>18</td>
<td>50</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>100</strong></td>
<td><strong>101</strong></td>
</tr>
<tr>
<td><strong>n</strong></td>
<td><strong>38</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>
Junior hospital doctors are not only considerably more mobile than general dental practitioners. They are also more likely to be living in an area in which they have found a job to their liking, whereas the general dental practitioner is likely to be practising in the area in which he has chosen to live for family, social or environmental reasons. This is evidenced by the considerations which respondents said had affected their decision to live in Edinburgh or,
Because some respondents gave more than one reason for having decided to live in Edinburgh, totals exceed 100%.

...
probing on the influence of a desire to live in a particular place on career decision-making. Only 13% of dentists, compared with 68% of hospital doctors, had never been influenced in career decision-making by a desire to live in a particular place.

**FACTORS DETERMINING MOBILITY**

The different mobility experiences of hospital doctors and general dental practitioners are to be explained in part by differences in the occupational structures within which they work.

As detailed in Chapter IV, hospital doctors work within hierarchic structures in which tenure of office is, until a consultant post is obtained, for a limited period only.6

Progress up this bureaucratic ladder is facilitated by remaining in a teaching system and by working for chiefs with established reputations. It is important for the newly graduated doctor to obtain a house job in his alma mater - those who do not later face the awkward question 'Why did you leave your teaching hospital?'. After that the young doctor's career is facilitated by remaining in his alma mater where he is known and where he knows who is who. As one doctor put it, 'Once you leave your own hospital, you fight a losing battle against the local lads, so I thought I would remain a local lad'.

However, if the junior hospital doctor is to remain in his teaching system, jobs appropriate to his training requirements and interests must become vacant at the right time. Further, competition must be such that, given his own ability, he is able to get the
available job. If job availability, competition and his own limitations are such that he cannot remain in his own teaching hospital, he must move, preferably into some other teaching system. And because each job is for a determined period he may find himself moving frequently. In most circumstances he feels he cannot afford to turn down an attractive job because he does not want to move or dislikes the place in which a job may happen to be available. If he were to do so, his career chances might be jeopardised. Or he might even find himself without a job. So he moves, and his mobility comes to an end only when he reaches the top of the hospital career ladder - when he becomes a consultant.

The general dental practitioner is in a very different situation. As detailed in Chapter IV, success in general dental practice depends on building up a local clientele and a local reputation. Consequently, it is in a dentist's interest to remain geographically stable.

Further, the general dental practitioner can, at the outset of his working life, decide where he would like to live on social, family or environmental grounds and then look for and obtain a partnership in an area in which he would like to live. His freedom of choice may be constrained by the availability of a partnership, but my data suggests that this constraint is not severe. Thus, in general, dentists decide where they would like to live and then hope to find the 'right' job in that area, whereas hospital doctors decide what is the 'right' job for them at a particular stage in their career and then hope to find this job in an area of the country that is to their liking.
However, the mobility experiences of hospital doctors cannot be explained only in terms of the career structure within which they work. The particular career path any hospital doctor treads is in fact determined by the career decisions he makes - by his decision to enter hospital medicine rather than general practice, by his choice of speciality and by his aspirations regarding a peripheral hospital/teaching hospital consultancy - and different career paths have different implications for mobility.

The decision to be a hospital doctor rather than a G.P. implies a readiness for geographical mobility, or at least no particular preference for geographical stability. Specialty choice may also have implications for mobility in that hospital doctors in undersubscribed specialties may have a greater range of jobs between which to choose, and may therefore be in a better position to consider environmental and mobility factors when making career decisions than doctors in oversubscribed specialties in which competition is intense. Further, teaching hospital/peripheral hospital aspirations influence decisions made during the course of a career. The hospital doctor who is aiming at a chair in a famous teaching hospital necessarily chooses to go where the best opportunities lie. The hospital doctor who is aiming at a consultancy in a peripheral hospital may take the second best and may, therefore, be prepared to take what is available in the area in which he is living rather than move.

The particular career path on which a hospital doctor finds himself is not forced on him by his occupational situation, but is chosen in the light of his life-plans and the place work plays in
his life-plans. Further, few of the particular job decisions made during the course of a career are forced on a hospital doctor by the objective availability of one and only one job. A range of jobs are usually available to him and the choice he makes between available jobs - and indeed his perception of the jobs that are available to him - is influenced by his occupational aspirations. Moreover, as I shall show later, junior hospital doctors and their wives (as well as general dental practitioners and their wives) believe that the family 'ought' to move when and where moving is necessary to the achievement of occupational aspirations.

The importance to hospital doctors of the achievement of occupational aspirations does not mean that family considerations are altogether ignored. Family considerations may be ignored when considering posts in the training grades since, hospital doctors argue, the chances of getting a 'desirable' consultant's post depend on holding 'good' posts in the training grades and such posts are temporary. But, some hospital doctors said, family and social considerations would play a part in their decisions regarding a consultant's job since this job is a permanent one. It seems that decisions regarding a consultant's post would involve a delicate balancing of the perceived advantages/disadvantages to the family and the desirability of any particular job. It is difficult to say what these men would in fact do when the time comes for them to consider a consultant's post but I was left with the impression that substantial weight would be given to family considerations only by those doctors who perceive themselves as having many job options. Ultimately,
career decisions are determined by the attractiveness of a particular job as defined by the extent to which that job seems likely to provide self-fulfilment. As one doctor put it, 'To me to be happy at work is more important than many of the things about my surroundings'. And in the words of another, 'I would never choose to live in a place just because it is attractive. I am far too committed to my job for that.'

In sum, the occupational structure of hospital medicine does not completely determine the mobility experiences of hospital doctors. While it is true that hospital doctors are at the risk of mobility in a way that general dental practitioners are not, it is also true that career decisions have implications for mobility and that these decisions are not forced on them by their occupational situation. There is a sense in which hospital doctors must go where opportunity lies, but opportunity rarely takes them in one direction only. And the direction in which they in fact travel is determined by decisions that are made in the light of their orientations to work.

THE CONSEQUENCES OF MOBILITY FOR FAMILY LIFE

So, while the general dental practitioner and his family lead a geographically stable life in a part of the country of their choosing, the junior hospital doctor and his family are geographically mobile. This mobility is problematic for family life and, insofar as it is problematic, is a source of socially-structured strain between the occupational system and the family system. The problems occasioned by geographical mobility were revealed by systematic probing following the question: 'In what, if any, ways has your family life, your wife's
and the children's /yours and the children's been affected by your/
your husband's work commitments?'.

The problems which respondents said they encountered fall into the following categories:
1. the physical upheaval;
2. the financial problem;
3. the unsettling effects for children;
4. isolation.

The frequency with which these problems were mentioned by junior hospital doctors, by general dental practitioners and by their wives is shown in Table 54. Doctors, in general, appear to regard geographical mobility as entailing few problems, the physical upheaval involved being the only problem they refer to with any frequency. Most doctors' wives, on the other hand, regard mobility as problematic. They speak particularly of feelings of isolation. For dentists and dentists' wives, mobility-occasioned problems are few in view of their very limited geographical mobility.

1. The Physical Upheaval

The physical upheaval that moving involves, mentioned by eight of the 29 mobile junior hospital doctors and by 10 of their wives, was variously described as a 'nightmare', a 'nuisance' and 'ghastly'. It involves selling and buying a house, packing and unpacking, buying furniture, curtains, carpets to fit the new house and re-arranging the children's schooling. In some instances this is made more difficult by having to move at very short notice. It is a
TABLE 54

PROBLEMS OCCASIONED BY GEOGRAPHICAL MOBILITY IN THE FAMILIES OF JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS

| Problems Mentioned | Doctors' Doctors\' Wives Dentists' Dentists' Wives |
|--------------------|------------------|-------------------|
|                    | (n = 33)         | (n = 33)          | (n = 16)          | (n = 16)          |
|                    | percentage       |                   |                   |                   |
| Physical upheaval  | 21               | 26                | -                 | -                 |
| Financial          | 11               | 5                 | -                 | -                 |
| Children           | 5                | 8                 | -                 | -                 |
| Isolation          | 11               | 47                | 6                 | 19                |
| No problems        | 47*              | 11                | 25*               | 13                |
| No mobility        | 24               | 24                | 69                | 69                |

* Refers only to husbands who did not themselves experience mobility-occasioned problems. That is, husbands who recognised the problems occasioned for their wives but who had no problems themselves are not included here.

Total per cent is more than 100 since some respondents name more than one problem.

situation in which couples may find themselves living in rented accommodation inappropriate to their needs, or living with parents or in-laws. In one case at least this was accompanied by severe conflicts.

2. The Financial Problem

The financial problem was referred to by four doctors and by two of their wives. Junior hospital doctors receive assistance with
removal expenses but it seems that in these instances at least the cost of moving was such as to occasion financial embarrassment in spite of the help received. Further, moving away from relatives adds a new item of expenditure to the family budget, that of visiting, or being visited by, relatives. 'We were just solvent before we came up here,' a respondent told me, 'but with the move and with having in-laws for our first Christmas we were very financially embarrassed.'

3. The Children's Problems

In two families children had experienced emotional disturbances which were attributed by their parents to the disrupting effects of mobility. The difficulties that were experienced in these cases may best be described by quoting from two of the interview schedules.

Case No. 8: The endless moving used to upset the children very much when they were small. The young one had started to talk at the time of one move - he was 14 months old. After we moved he became very unhappy. He cried a lot for no reason. He stopped talking completely. And when he did start talking again, he did not talk properly - he talked in a very odd way, and still does. And they do not like being left with anyone. Even the older one who is now at school and very happy there, will not go and play in other people's houses. But I find it distresses them less the older they grow and become able to understand it.

Case No. 16: Definitely moving house three times affected our little boy very much. He became very insecure - you had to sit with him at nights; he sucked his fingers desperately; he was sometimes very difficult. One of the advantages of this house is that living here has done wonders for him.

Disruption of children's schooling, a problem that mobile families might be expected to experience, was not much experienced by these families since few couples had children of school age. Disruption of schooling was referred to in only two cases (once by a husband and
once by a wife) but anxiety about the possibility of disruption in the future was voiced by a few respondents.13

4. Isolation

The weakening of social relationships consequent on mobility has frequently been argued14 and, as I showed in Chapter I, it has often been suggested that the active participation by husbands in family life represents a solution to the problems and isolation consequent on mobility. Doctors' and dentists' wives, like the subjects of other studies, find the isolation consequent on mobility particularly problematic, more so than physical upheavals, financial difficulties and disturbed children. But, as I shall show later, mobile doctors' wives are in fact deprived of the participation of their husbands in family life by virtue of the demands hospital medicine makes on their time. Here, I attempt to describe the feelings of isolation they experience as a result of mobility.

Doctors' and dentists' wives find mobility isolating both because it severs long-established ties with relatives, friends and neighbours, with a place, its shops and institutions, and because it places them in a new and unfamiliar situation.

The effect of mobility on the disruption of relationships with kin is demonstrated in Table 5:5. With one exception, respondents native to Edinburgh or the Lothians have parents or siblings living fairly close at hand (that is in Edinburgh or the Lothians). By contrast, only a few of the respondents who are not native to Edinburgh/Lothians have parents or siblings living close at hand.15 This means that,
TABLE 5:5 RELATIONSHIP BETWEEN GEOGRAPHICAL MOBILITY AND PROXIMITY TO RELATIVES

<table>
<thead>
<tr>
<th>Place of origin of respondents</th>
<th>Siblings and/or parents in Edinburgh/</th>
<th>Not in Edinburgh/</th>
<th>Percentage of total sample</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lothians</td>
<td>Lothians</td>
<td>Dentists (n = 16)</td>
<td></td>
</tr>
<tr>
<td>Native to Edinburgh/Lothians</td>
<td>50</td>
<td>-</td>
<td>50</td>
<td>8</td>
</tr>
<tr>
<td>Not Native to Edinburgh/Lothians</td>
<td>-</td>
<td>50</td>
<td>50</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>50</td>
<td>100</td>
<td>16</td>
</tr>
<tr>
<td>Doctors (n = 37++)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native to Edinburgh/Lothians</td>
<td>16</td>
<td>-</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Not native to Edinburgh/Lothians</td>
<td>14</td>
<td>70</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>70</td>
<td>100</td>
<td>37</td>
</tr>
<tr>
<td>Dentists' Wives (n = 16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native to Edinburgh/Lothians</td>
<td>25</td>
<td>6</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td>Not native to Edinburgh/Lothians</td>
<td>19</td>
<td>50</td>
<td>69</td>
<td>11</td>
</tr>
<tr>
<td>TOTAL</td>
<td>44</td>
<td>56</td>
<td>100</td>
<td>16</td>
</tr>
<tr>
<td>Doctors' Wives (n = 37++)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native to Edinburgh/Lothians</td>
<td>13</td>
<td>-</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Not Native to Edinburgh/Lothians</td>
<td>14</td>
<td>73</td>
<td>87</td>
<td>32</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27</td>
<td>73</td>
<td>100</td>
<td>37</td>
</tr>
<tr>
<td>All Respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native to Edinburgh/Loth.</td>
<td>22</td>
<td>1</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Not native to Edin./Loth.</td>
<td>12</td>
<td>65</td>
<td>77</td>
<td>82</td>
</tr>
<tr>
<td>TOTAL</td>
<td>34</td>
<td>66</td>
<td>100</td>
<td>106</td>
</tr>
</tbody>
</table>

+ n = 37 as one doctor had no relatives.
++ n = 37 as one doctors' wife had no relatives.
given the differential mobility of hospital doctors and general
dental practitioners, about one-half of dentists and of dentists'
wives, but just one-fourth of hospital doctors and of doctors'
wives have parents or siblings near at hand. 16

It may take mobile wives some time to become familiar with
their new situation, its shops and facilities, and to build up new
relationships with neighbours and friends. Until they do so, they
are cut off from the locality social system and may experience acute
feelings of isolation, of non-belongingness. If moves are frequent,
then the feelings of non-belongingness are on-going. As one wife put
it, 'Constant moving means that every friend is an impermanent friend'.
Moreover, the difficulty of making new relationships may be compounded
by the mobility of others - not only does the mobile wife move away
from friends, but new-found friends may move away from her. 'That is
the terrible thing with professional people', one wife told me,
'they are always moving. Unlike office workers.'

For some doctors' wives, feelings of non-belongingness may be
generated not only by the actuality of moving, but also by the
expectation of moving. Their accounts of the problems of mobility
suggest that the expectation of being on the move contains an element
of uncertainty about the future which may be experienced as 'unsettling',
'like being in limbo, waiting for a decision that can't be yours'; as
involving the 'imponderable' about which it is difficult to be
enthusiastic, the 'unknown' which can only be 'feared'; as making it
difficult to plan for the future - for the children's education, for
embarking on training so as to return to work, for house-buying. 17
Exacerbating factors

The isolation wives experience on moving may be exacerbated where circumstances make the forging of links with the locality social system particularly difficult. Circumstances which wives in my samples reported as exacerbating their isolation included being 'tied' by a young baby, deprivation of a husband's company as a result of the demands of his new job, personality difficulties in making friends, difference from the local community by virtue of certain social characteristics - by, for example, being English and/or Roman Catholic in Edinburgh. Even the time of year at which a move is made may, in some cases, increase the difficulties of forging links in the local social system. One respondent who had moved in the late autumn found that she did not make contact with her neighbours until the following spring when she and they ventured out into their gardens. Until then she had scarcely seen her neighbours.

The structure of the receiving neighbourhood community is an important factor in easing the formation of social relationships. Wives who had moved on to a new private housing estate, where most couples are in the family-bearing stage of the life-cycle and are always going and coming, found it relatively easy to forge relationships with the neighbours. In such a situation, social networks are fluid and easily admit the stranger. Neighbouring wives may, it seems, gather round to welcome the newcomer with offers of coffee and assistance. The in-coming couple quickly become members of a neighbourhood social network, albeit a fragile network of people brought temporarily together by their common condition of mobility.
On the other hand, wives who had moved into old-established parts of Edinburgh, such as The Grange or Morningside, with a mixed age structure, long-established social networks which tend to constitute enclaves that exclude the stranger and large walled gardens which preclude easy physical contact with neighbours, found it difficult to forge social links.

The reaction of husbands to the isolating effects of mobility

Isolation is a wife's problem. Only four doctors and one dentist in the sample had ever missed the social life they had previously enjoyed on moving to a new place. Doctors, in fact, find that they are bound into the locality social system by their work and through colleague networks. As one doctor put it, 'You go straight into a job and colleagues become your friends'.

Perhaps because they do not experience this feeling of isolation from the locality social system, husbands seem unable to sympathise with their wives' experiences. Husbands may acknowledge that their wives are lonely and isolated, but wifely distress seems to evoke irritation rather than sympathy. Significantly, husbands did not once, in the course of interview discussions of this question, admit responsibility for the situation in which their wives are placed or suggest that they had a role to play in alleviating their distress. As one husband wryly admitted, 'I didn't do anything about it', adding, 'I don't think I fully appreciated the problem at the time'.

Husbands generally seem to think that their wives are willing to support them and so to 'string along' in spite of the problems involved. In the words of one husband, 'My wife accepts it. What
matters to her is being able to support me. And if she feels she is doing this, the happier she is.21

Given the expectation that wives should be prepared to move, reluctance to move may lead to husband-wife conflict.22 This may be illustrated by the experiences of two couples.

The first couple had come to Edinburgh from another part of Scotland and were on the point of moving South of the Border at the time of the interview. She did not want to leave Edinburgh.

Case No. 38, wife's view: There was a job offered him here. But he wanted to move because the unit in.... is good and the Consultant has a good reputation. If we stayed here, he would be in a rut. At first, I thought he was too ambitious - why couldn't he just take the jobs that are going like everyone else. There was a job going in Edinburgh which he could have had. And we sat down and thrashed it out and I realised that what he said made more sense than what I was trying to say. The job was in a much better unit. I really didn't want to come here either. I felt much the same about coming here as I do about going to.... I was home-sick. I kept going home every weekend. So I decided the only thing to do was to go out to work. So I did part-time nursing and made a lot of friends. Now I love Edinburgh and don't want to move. It's the uncertainty of not knowing where we are going to be that I don't really like. And it will be like that for the next 12 years.

And her husband's view of the situation: For my wife it will involve a considerable upheaval, but the job is of paramount importance. So far the family has had to take second place. And as far as I can see into the future that is how it will remain until the very last job. I don't think that at this stage in your career you can give the place much consideration.

The second couple had come to Edinburgh from South of the Border and had lived in Edinburgh for seven years. This is how they spoke of their situation.
Case No. 21; wife's view: Not knowing anyone is more
difficult for wives than husbands and here it takes a
year to get to know anyone. That was the worst part.
And being English and Roman Catholic in Edinburgh tends
to make you seem an odd ball anyway.

When we came here, to get me up here, he said it would be
for 18 months. When he goes for an interview for a job,
I always hope that this means we'll be moving. If he
doesn't get it, I find it more of a let down than he does.

And her husband's view of the situation: My wife disliked
the move very much. I felt I had to support her a good
deal and perhaps unreasonably I felt why should I have to
support her. I've got to get on with my job. I was not
very sympathetic. She didn't know anyone. I was often
late home and she found it trying. I had to take the
initiative, suggest night school, going back to work. She
felt I wasn't cognisant of her unhappiness, and I felt it
was clear that I had come for the job and that I would
have re-orientation stress.

ATTITUDES TO MOBILITY

In spite of the problems geographical mobility brings with it,
junior hospital doctors, general dental practitioners and their wives
are almost unanimous in according legitimacy to work-generated mobility.
They believe that men should be free to pursue their career goals
since it is in the achievement of career aspirations that men find
happiness and the happiness of the husband-father is essential to
the happiness of the family. This ideology, which legitimizes not
only work-generated mobility but also the subordination of material
interests to the search for psychic satisfactions in work, serves
to mitigate the socially structured conflict that exists between work
and family in terms of the disjunction between occupation system needs
for mobility and family system 'needs' for stability.

The legitimation of work-generated mobility is revealed by
responses to the following hypothetical question:
I am going to recount a hypothetical situation and I would like you to tell me what you think the man concerned should do. Mr. X has been offered a job which he really wants but this job entails moving away to another town and his wife does not want to move to a place in which she would know no-one. What should he do?

**Table 5:6**

**ATTITUDES TO GEOGRAPHICAL MOBILITY**

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Hospital Doctors</th>
<th>Doctors' Wives</th>
<th>Dentists</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. X should take new job involving mobility though wife does not want to move away from family &amp; friends</td>
<td>71</td>
<td>79</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Mr. X should not take new job</td>
<td>5</td>
<td>5</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>24</td>
<td>16</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>38</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

Most respondents think that the hypothetical Mr. X should take the job and move (Table 5:6). Some are ambivalent but only a very few think that he should not take the job. The fact that even general dental practitioners and their wives, who are not themselves involved in a work situation that generates mobility, seem to legitimate mobility suggests that this may be a middle-class cultural norm.23

Work-generated mobility is, in the view of both husbands and wives, legitimate where the fulfilment of career aspirations is
dependent on moving. 'His priorities are his work commitments.'

'Her main interests should be her husband's, not her own happiness.' Hence wife and family must expect to move. In this context, wives more frequently than husbands, used the word 'duty'. 'It is his life and her duty to go.' In effect, both husbands and wives define the wifely role as involving support of husbands in the pursuit of occupational goals, and, therefore, the acceptance of mobility where mobility is necessary to the achievement of these goals.

But the justification for the acceptance of mobility rests not only on the necessity of mobility for the achievement of success and happiness in work, but also on the consequences that the achievement of job-satisfaction is seen as having for family life. A job that benefits a man, benefits his family in terms of income and status. But more than this, the integrity of the family is dependent on the husband's happiness and his happiness is, it is said, dependent on his achievement of job satisfaction and the fulfilment of occupational goals. The following extracts from the husbands' interview schedules illustrate this view:

Case No. 6: What sort of family life would a family lead if a man were to accept an unsatisfactory job situation so that his wife could remain near her family and friends?

Case No. 15: The alternative is impossible, the man staying and doing a job he doesn't want to do. It doesn't lead to mutual goodwill. I think any mature person would realise this and go.

Case No. 4: If he didn't go, he would be blaming her for the rest of his life.

So the hypothetical Mrs. X must accept the difficulties that may be involved for her, the unhappiness she may experience by virtue
of mobility. Her unhappiness is not expected to threaten the integrity of family life. Or rather she ought not to be unhappy. Her situation is seen as more adaptable than that of her husband’s. He may experience considerable difficulty in getting a job to his liking without moving, but she should be able to adapt to her new surroundings and make new friends. In the view of one hospital doctor (a psychiatrist), the reluctance to move spring simply from a fear of the unknown. Several men regard the hypothetical Mrs. X as being too attached to her family and seem to think that, in any case, it is time she was taken away from them.

Many respondents were in fact extremely critical of Mrs. X. She was variously referred to as ‘a fool’, ‘a Mammy’s girl’, ‘selfish’, ‘immature’, or ‘lacking in adventure’ by doctors and dentists, husbands and wives alike. Some of the men felt that Mr. X had been unfortunate in his choice of a wife.

Wives are, however, somewhat more sympathetic to Mrs. X than the men. More frequently than their husbands they say that her attitude is ‘understandable’, that moving can be ‘a wrench’, ‘tough’, ‘overwhelming’. Clearly, some wives, though they believe that work-generated mobility must be accepted, also regard the wrench it creates with alarm. They may accept the need for mobility, but they also dislike it. The way in which some wives may be torn between their belief that they must accept mobility in the interests of their husbands career and their reluctance to move is vividly illustrated by the following responses:
Case No. 30. A hospital doctor's wife who has not in fact experienced mobility:
At one time it was clear to me that a man's career is everything. It is less so now. But basically if he is sure about the job, he should go.

I would be more sympathetic to the wife than I would once have been. It is more difficult for women. They are more dependent on the home. They are trapped in it. On the other hand it is bad for a marriage if the husband feels that she has held him back. And a change could lead to interesting things.

Case No. 36, a hospital doctor's wife who has not yet experienced mobility:
I am slightly involved in this. My mother is on her own and my ties to Edinburgh are strong. We have discussed this at length and, if we move for what is to be a long-term job, we'll take my mother with us. We wouldn't take her if it were only to be a short-term job. It wouldn't be worth uprooting her.

In medicine one has to be prepared for moving as one must be prepared for the hours. You have to go where the jobs are. And I may say it was a long time before I faced up to this. Until recently the thought of moving horrified me. Our situation could not be more complicated. My mother is on her own. She was an only child and I'm her only child. It won't be easy (moving) but I've got used to it. It's the sort of thing that's best talked out and faced before the situation arises, rather than waiting till the time to move actually comes. As a wife, your first loyalty is to your husband. It's tough on Mum's left behind. But your first duty is to your husband and parents come second. It has to be talked out with your husband of course and he perhaps has to be reconciled to the idea of having Mum in the family, or at least making arrangements so that she can live nearby.

But her husband's view of their situation highlights the underlying conflict between husband and wife over this issue:

Moving would be good from the professional point of view. From the family point of view it might not be a bad idea either.... (his wife) has never been anywhere else. She feels she has a responsibility to her mother. But she has responsibilities of her own now and might be well away from her mother for a while.

Case No. 37, The wife of a doctor who is about to take up a position in the South: He has got to take the job if he really wants it. It is exactly the position I am in just now.
My initial reaction - delight for my husband that he had got a good job and delight at the prospects it has opened up - the status, the better standard of living, the new horizons. Then when you think about it, you wonder if you are doing the right thing - you worry about being uprooted. But if things are going badly with your husband and you have had a row, you would not be able to put on your coat and go and have a chat with your sister or a close friend. But that is not enough to stop you going unless you are heading for the divorce courts.

APPENDIX: The estimation of rates of mobility

In measuring mobility rates I was concerned to establish rates which would reflect the frequency with which social relationships are disrupted and must be reformed. This approach is dictated by the theoretical concerns of this study. In the light of this concern, the following conventions were adopted in determining whether or not a move constituted a unit of mobility:

1. Mobility was defined as movement between urban areas (or between villages or from a village to an urban area). That is 'local moves' occurring between neighbourhoods within the same urban area or between the city and its suburbs (up to a distance of seven miles from the city centre) were discounted.

2. A return move to a place in which a couple had previously lived was discounted if (a) the couple had lived in that place for at least a year before moving away and (b) if they returned to it within a year of having moved away.

3. Where mobility occurring as a result of National Service is concerned, the moves involved in joining the Services and in returning to civilian life were regarded as constituting mobility, but moves made during the Service period were discounted.
4. Where a couple began marriage in a place other than that in which the wife was living immediately prior to marriage, the movement involved was counted. That is, rates of mobility after marriage refer to the number of moves made by wives.

A mobility rate of this kind has its limitations. Firstly, it takes no account of differences in the type of community between which movement occurs. Geographical mobility may involve moves from close-knit to loose-knit communities, from old-established neighbourhoods to new housing estates, between rural areas, small market towns, industrial cities or non-industrial cities, and indeed between continents. The problems involved in establishing social relationships in different types of communities will obviously differ.

Secondly, it takes little account of the distances over which mobility occurs. It does not distinguish between mobility between, say, West Calder and Edinburgh and London and Edinburgh, though in the latter case relationships with friends and kin are likely to be more severely curtailed than in the former case.

Thirdly, it takes no account of the fact that though a couple may be stable their friends and kin may not. In this case disruption of relationships is brought about by the mobility of other people.

Even so, a mobility rate does provide some crude indication of the frequency with which social relationships are disrupted and must be re-formed.
CHAPTER VI

The Problem of Heavy Workloads

FACTORS DETERMINING WORKLOADS

Three factors inherent in the structure of hospital medicine shape the working week of junior hospital doctors and tend to make their workloads heavy: firstly, the needs of their clientele; secondly, the authority structure of hospital medicine; and thirdly, the training programme. The workload of the general dental practitioner is only minimally subject to these constraints and is to a considerable extent the outcome of a process of accommodation between desired income and desired 'leisure' time.1

1. Clientele needs

The working time of hospital doctors is largely shaped by clientele needs. Patients require attention round-the-clock, and frequently under emergency conditions. The problem of providing a 24-hour emergency service is resolved by means of an on-call system in which there are 'normal hours of work' when all doctors are on duty;2 on call duty hours - those hours of the evening, night and weekend when specified doctors must be immediately available for duty within the hospital; and standby duty - those hours of the evening, night and weekend when specified doctors must be available but not immediately available for duty and so are not required to remain on hospital premises.

The amount of off-duty time available to junior hospital doctors as of right was formally specified only in 1967. In that year Ministry memoranda recommended that 'subject to the overriding
priority of dealing with patients' needs, junior staff should have as assured periods of off-duty time one afternoon a week, alternate nights (normally from Monday to Thursday) and alternate weekends (from Friday evening to Monday morning). 3

The way in which, and the extent to which, these recommendations are implemented varies from hospital to hospital and is to a considerable extent dependent on the staffing situation in a particular region, hospital organisation and specialty needs. A survey by the South-Eastern Regional Hospital Board (Scotland) suggests that in this region the weekend tends to begin after lunch on Saturday and that 56% of junior hospital doctors have less than the recommended off-duty time per week. 4 The study also shows that it is in the para-clinical specialties and in psychiatry that recommended off-duty time is usually achieved, while only a small proportion of doctors in medical and surgical specialties achieve the recommended off-duty time. 5 A subsequent report by this Hospital Board shows that academic staff are in a better position than N.H.S. staff. Only 11% of academic staff have less than the recommended amount of off-duty time. 6

A doctor who is on call may not, of course, spend much of the time working. However, his primary responsibility while on call is to his patients and his freedom of action is constrained even though he may not be actively involved in caring for patients. The extent to which his services are likely to be required varies from specialty to specialty. Doctors in specialties with a high emergency quotient are likely to spend a greater proportion of their time on call actually working than the doctors in specialties with a relatively low emergency quotient. 7
The working time of the general dental practitioner is also constrained by the needs of his clientele, but the extent of this constraint is limited. Patients are usually dealt with by appointment within the confines of a 'normal' working week. Clientele needs do not often assume emergency proportions; so the dentist rarely needs to return unexpectedly to his surgery and his working day is predictable. 'Toothache' cases must, it is true, be given immediate treatment in what may be an already fully booked day; and this may mean working into the lunch hour or beyond the scheduled departure time in the evening. But many dentists leave some time free for unscheduled 'toothache' cases so as to minimise the extent to which their day is disordered by emergencies. Some provision must also be made for patients who cannot see their dentist within the confines of the 'normal' working week and this may be done through Saturday morning or evening surgeries. This kind of provision is, however, limited. Further, the independence which the dentist enjoys in his working situation enables him, if he should so desire, not to make or to cancel late appointments or Saturday morning appointments.

2. Authority structures

A second important factor in the working time of the junior hospital doctor is the pattern of clinical organisation in the hospital service. This is based on a tradition of consultant responsibility which assigns to the consultant full responsibility for the complete medical care of all patients within his particular specialty. Within his ultimate responsibility, the consultant
delegates work and clinical decisions to his supporting staff of house officers, registrars and senior registrars. Responsibility is delegated downwards to supporting staff in accordance with their status in the hospital hierarchy. But the normal chain of referral is upwards from nurse to house officer, from house officer to registrar and from registrar to consultant. This means that the brunt of emergency calls is in fact born by junior staff while senior registrars and consultants are called out only to deal with cases with which their subordinate staff feel unable to cope. Thus a consultant who may technically be on call at all times (and who is never free from overall responsibility for patients) may rarely return to the hospital for emergency cases after 6.00 p.m. or at weekends, while his pre-registration houseman is required to be resident in hospital to be readily available for emergencies and his registrar is more likely to be called out.3

While the working time of the junior hospital doctor is to a considerable extent defined by the authority structure of the hospital service, the general dental practitioner exercises considerable control over his working time. His independence enables him to determine for himself, or in collaboration with his associates and partners, the number of hours he will work and when he will work. The individual practitioner determines whether or not he will cater to clientele needs by running Saturday morning or evening surgeries. If he does run them, he is free to cancel them should he wish to do so.

3. Training

The workload of the junior hospital doctor is also influenced by
the fact that he is a doctor in training. In order to become a specialist in any particular area of medicine, he must pass qualifying examinations for membership of the Royal College for that specialty. This entails continuous study over a period of 1-2 years. Once admitted to the Royal College of his chosen specialty, 'study' continues to be necessary since medical literature must be kept up with, and research and publication facilitate progress up the hospital hierarchy. Further, senior doctors are increasingly involved in postgraduate medical education and in committee work.

Much of this kind of work must be done in the evenings or at weekends. Provisions for study leave have only recently been formalised. Ministry memoranda of 1967 and 1968 recommended that staff in the registrar and post-registration house officer grades should have study leave of up to 30 days a year and that senior registrars should have professional leave of 10 days a year for attendance at conferences.\(^9\) The extent to which study leave is in fact available varies between hospitals. The Management Services (M.S.S.) study on the Organisation of the Work of Junior Hospital Doctors\(^10\) found that at one end of the scale study leave was easily obtained, while at the other end of the scale study leave was difficult to obtain without offending senior medical and administrative staff. The Northampton survey found that 39\% of hospital doctors were getting 'less' and 43\% 'much less' study leave than the recommended amount,\(^11\) while Easton in his study of the Eastern Region of Scotland found that 40 out of 112 registrars and senior house officers were getting less than five hours time for personal study per week and 23 were
getting no time at all. But even where study leave is available, hospital doctors frequently find that evenings and weekends must be spent in personal study, research and the reading of work-related literature.

For the dental practitioner, on the other hand, evening 'homework' is limited. Reading work-related literature may consume some time, but as a fully qualified and independent professional he is free from the pressures of examination passing and from the commitment to research and publication that is necessary for career-advance in hospital medicine.

In sum, the working time of the hospital doctor is greatly affected by the needs of his clientele, whereas the working time of the dentist is not. As a result of the different needs of their different clienteles, the hospital doctor is generally required to work in what would normally be regarded as leisure time, the dentist is not. Secondly, the hours at which the hospital doctor works are determined for him by the hierarchic structure within which he works, while the dentist has some control over how much he will work and when he will work. Thirdly, the hospital doctor, unlike the dentist, is a professional in training who must equip himself both for the practice of an expertise and for a competitive struggle for status within a hierarchically structured organisation.

In fact, the considerable autonomy the general dental practitioner enjoys means that he is to a considerable extent free to order his working day as he wishes. This factor, in combination with the method of remuneration found in general dental practice, means that his workload
tends to be the outcome of a process of accommodation between desired income and desired leisure time. As I showed in Chapter IV, income in general dental practice is broadly related to number of hours worked in that remuneration is based on payment for each item of service performed. Fees are fixed at rates intended to ensure that after practice expenses have been met a target average net income is achieved in a standard number of hours.¹⁴

This means that the individual general dental practitioner can increase his income by increasing the number of services he performs. He may do this either by improved techniques and equipment and the streamlining of practice organisation or by working longer hours. On the other hand, it also means that he can increase his leisure time either by so improving his techniques that he reaches the target average net income in less than the standard number of hours or by having as his goal an income which is less than the target average net income.

In fact, in recent years, advances in dental technology (particularly the introduction of the air rotor drill) together with increased personal effort have enabled the dental profession as a whole to increase their income while reducing the number of hours worked. The average number of hours worked annually by a principal was 2000 in 1966-1967 compared with an average of 2,120 in 1963.¹⁵ During this period gross earnings rose by 11%.¹⁶ This trend has continued.¹⁷

At the same time those for whom work is self-expression and self-fulfilment are likely to spend more time on the job than those—
for whom it is not. For example, hospital doctors who are committed to work for its own sake will devote time to the reading of work-related literature even when this is not necessary to the attainment of occupational position. Similarly, the amount of time a hospital doctor spends in patient care when on call is influenced by his attitudes to patient care, by, for example, his belief in the importance of continuity and the personal element in patient care.

As I have shown, hospital doctors generally enter hospital medicine because they believe it is a rewarding area of work and in general find it to be rewarding. We may therefore expect the situational constraints which tend to make for heavy workloads to be reinforced by the values and attitudes they bring to work. General dental practitioners, on the other hand, seem to experience their work as 'sheer graft' but would at the same time like to achieve both high earning power and self-fulfilment in work. Given their freedom from workload constraints, we may expect that they will seek to organise their working day so as to achieve the best possible balance between income and leisure time.

I now turn to a consideration of the workloads of junior hospital doctors and general dental practitioners in terms of the number of hours worked.

**PARTICIPATION IN WORK, FAMILY LIFE AND NON-FAMILIAL LEISURE**

In order to explore the outcome of the factors impinging upon the working time of junior hospital doctors and general dental practitioners in terms of the amount of time spent in work and,
consequently, in non-work activities, respondents were asked to keep a diary for the week following the interview. They were asked to time three categories of activities: work, familial activities and non-familial leisure. All time not recorded as having been spent in these activities was assigned to a residual fourth category consisting of sleep, meals, physical care of the self and unaccounted for time.22

Workloads

The number of hours spent in work during the week for which respondents kept diaries is shown in Table 6:1.23 As is readily evident, the workload of general dental practitioners, while not light is considerably lighter than that of junior hospital doctors;

<table>
<thead>
<tr>
<th>No. of hours worked</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
</tr>
<tr>
<td>up to 40 hours</td>
<td>-</td>
<td>25</td>
</tr>
<tr>
<td>41-50 hours</td>
<td>18</td>
<td>63</td>
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<td>51-60 hours</td>
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<tr>
<td>61-70 hours</td>
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<td>82</td>
</tr>
<tr>
<td>over 70 hours</td>
<td>21</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>
Eighty-eight per cent of dentists worked 50 hours or less, while 32% of junior hospital doctors worked more than 50 hours. Further, the circumstances of the two dentists whose workload exceeded 50 hours were exceptional. One was a man who had two practices, one in Edinburgh and one in a neighbouring city and some, though by no means all, of his workload is therefore to be accounted for by travelling time. The second dentist held evening surgeries every day. These seem to have been instituted to help finance the business enterprises on which he was about to embark.

The invasion of the evening and weekend by work

A heavy workload necessarily entails working in what might normally be regarded as non-work time, that is in the evenings and at weekends. Table 6:2 compares the extent to which the evenings of junior hospital doctors and general dental practitioners were invaded by work during the week under observation. Very few men did not work beyond 6.00 in the evenings, but, as we would expect given the heavier workload of hospital doctors, the invasion of the evening by work is more extensive among hospital doctors than among dentists. Sixty-nine per cent of the dentists had an evening workload of five hours or less, whereas seventy-four per cent of the doctors had an evening workload exceeding five hours.

The extent to which the weekend of junior hospital doctors and general dental practitioners is invaded by work is shown in Table 6:3. The dentists' weekend is not greatly threatened by work. During the week under observation just over half the sample had a work-free weekend and most of the dentists who worked at weekends did so for no more than five hours.
By contrast only 3% of hospital doctors enjoyed a work-free weekend while more than half worked for more than five hours.

<table>
<thead>
<tr>
<th>No. of hours spent in work after 6.00 p.m.</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 hrs</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1-5 hrs</td>
<td>24</td>
<td>63</td>
</tr>
<tr>
<td>6-10 hrs</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>11-15 hrs</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>over 15 hrs</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>

* This includes 4 doctors who slept in the hospital for one night during the week & 2 doctors who slept in for 2 nights.

<table>
<thead>
<tr>
<th>No. of hours spent in work at the weekend</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 hrs</td>
<td>3</td>
<td>56</td>
</tr>
<tr>
<td>1-5 hrs</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>6-10 hrs</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>11-15 hrs</td>
<td>12</td>
<td>59</td>
</tr>
<tr>
<td>over 15 hrs</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>
For nearly all the dentists time spent working after 6.00 in the evening or at weekends is time spent out of the home, seeing patients (Table 6:4 and 5).

On the other hand, hospital doctors, when they work in the evening, are as likely to work at home as in hospital. This is some indication of the amount of time spent in preparing for examinations, theses and lectures, and in reading work-associated literature. 26

It would seem, however, that most hospital doctors, do not devote a great deal of time at weekends to this kind of work. Time spent working at the weekends is for the most part time spent in hospital caring for patients.

Participation in family life and non-familial leisure

The length of the working week affects the amount of time available for family life and for non-familial leisure. Obviously, we may therefore expect general dental practitioners, by virtue of their lighter workloads, to spend more time in family life and in non-familial leisure than junior hospital doctors. 27

Participation in family life, as measured by the number of hours spent in family activities, is shown in Table 6:6. As this table shows, 50% of dentists, compared with only 13% of hospital doctors, spent more than 35 hours in family activity during the week for which diaries were kept. 28 At the other extreme one-third of the hospital doctors compared, with one-fifth of the dentists, spent 20 hours or less in family activity. 29
<p>| No of hours worked | Doctors | Dentists |         |         |        |         |        |         |        |        |         |         |        |         |        |         |        |        |         |         |        |         |        |
|-------------------|---------|----------|---------|---------|--------|---------|--------|---------|--------|---------|---------|---------|--------|---------|--------|---------|--------|---------|---------|--------|---------|--------|
|                   | Percentage | % N     | Percentage | % N     |        | Percentage | % N     |        | Percentage | % N     |        | Percentage | % N     |        | Percentage | % N     |        | Percentage | % N     |        | Percentage | % N     |        |
| 1-5 hrs           | 50       | 50       | 100     | 8       |        | 20       | 80     | 100     | 10     |        | 100     | 100     | 100     | 10     |        |        |        |        |        |        |        |        |
| 6-10 hrs          | 70       | 30       | 100     | 10      |        | 67       | 33     | 100     | 3      |        | 100     | 100     | 100     | 3      |        |        |        |        |        |        |        |        |
| 11-15 hrs         | 14       | 86       | 100     | 7       |        | -        | 100    | 100     | 1      |        | 100     | 100     | 100     | 1      |        |        |        |        |        |        |        |        |
| Over 15 hrs       | 25       | 75       | 100     | 8       |        | -        | 100    | 100     | 1      |        | 100     | 100     | 100     | 1      |        |        |        |        |        |        |        |        |</p>
<table>
<thead>
<tr>
<th>No. of hours worked</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td>% N</td>
</tr>
<tr>
<td>1-5 hrs</td>
<td>15</td>
<td>85</td>
</tr>
<tr>
<td>6-10 hrs</td>
<td>30</td>
<td>70</td>
</tr>
<tr>
<td>11-15 hrs</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>over 15 hrs</td>
<td>17</td>
<td>83</td>
</tr>
</tbody>
</table>
Table 6:6 shows that, while there is some tendency for dentists to spend more time in non-familial leisure activity than hospital doctors, non-familial leisure plays little part in the lives of either hospital doctors or dentists. In other words both groups of men seem to divide their time, albeit in different ways, between work and family.

Table 6:7 Amount of time spent in non-familial leisure by junior hospital doctors and general dental practitioners

<table>
<thead>
<tr>
<th>No. of hours spent in non-familial leisure activities</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 hours and less</td>
<td>76</td>
<td>50</td>
</tr>
<tr>
<td>6 - 10 hours</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>over 10 hours</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>total</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>
The effect of workload on family life

As workloads increase, non-work activities obviously decrease.
It is, however, of interest to attempt to establish whether or not there are differences in the extent to which different areas of non-work activities are squeezed. Table 6:8 suggests that as workloads increase from below 40 hours to 60 hours, men cut down on non-familial leisure and on sleep and other non-recorded activities, while participation in family life remains fairly stable. In other words, family activities seem to be given priority over non-familial leisure and sleep. As the workload rises above 60 hours, the amount of time spent in family activities drops considerably. Only a modicum of non-familial leisure is now retained and the amount of time spent in sleep drops further, particularly among men working over 70 hours.

<table>
<thead>
<tr>
<th>Workload</th>
<th>Average No. of hours spent in familial activity</th>
<th>Average No. of hours spent in non-familial leisure</th>
<th>Average No. of hours spent in sleep &amp; other non-recorded activities</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 hrs &amp; less</td>
<td>30.5) 32.2)</td>
<td>12.3) 10.4)</td>
<td>38.1) 34.2)</td>
<td>4</td>
</tr>
<tr>
<td>41 - 50 hrs</td>
<td>33.9) 8.0)</td>
<td>76.6) 13)</td>
<td>71.2) 7</td>
<td></td>
</tr>
<tr>
<td>51 - 60 hrs</td>
<td>30.5</td>
<td>4.9)</td>
<td>76.3) 13)</td>
<td></td>
</tr>
<tr>
<td>61 - 70 hrs</td>
<td>24.9</td>
<td>1.3)</td>
<td>71.2) 7</td>
<td></td>
</tr>
<tr>
<td>over 70 hrs</td>
<td>17.3</td>
<td>2.4)</td>
<td>71.2) 7</td>
<td></td>
</tr>
</tbody>
</table>
In a sense the reduction of sleep and other non-recorded activities is also a reduction of time spent in familial activity since it is a reduction of time spent in the home. Such participation may be passive, but may nonetheless be important. Where, for example, a man works so late that his wife precedes him to bed, going to bed is not the shared activity it might otherwise have been. Where a man returns home so late that his wife and children have already eaten, meals have not the flavour of the familial occasion they might otherwise have had - they become merely a refuelling stop. From this point of view, the reduction in hospital doctors' family activity occasioned by heavy workloads is greater than would appear from the measurement of participation in domestic tasks, child care, and familial leisure.

The impingement of family life on work activity

Thus far I have treated the relationship between workloads and family activity as a one-way affair: I have assumed that work activity is the independent variable, so that family activity simply increases or decreases in response to changes in work activity. This is an oversimplification for, in fact, even while participation in family life is being limited by heavy workloads, the amount of time devoted to work may, at the same time, be curtailed by pressures from the family sphere.

The effect of family activity on work activity was explored by specific probing to husbands following the question: 'In what if any way has your work life been affected by family commitments?' Forty-two per cent of junior hospital doctors but none of the general dental practitioners felt that work activity was affected in some way by the demands of family life.
Restriction of work activity may take place in one of three ways.

Firstly, hospital doctors may enter specialties which are relatively less demanding of time and energy. These may be underpopulated specialties in which the competition for position is less intense than in overcrowded specialties, or they may be specialties in which the 'emergency quotient' in patient care is relatively low. Five hospital doctors in my sample had attempted to keep work within a clearly defined place in their lives in this way. As one of these respondents put it, 'One reason for choosing psychiatry was that I didn't think I would have had the stamina for other degrees. If you've young kids, inevitably you don't put in as much time (on work) as you would like to. It's important to take them out or you feel guilty if you don't.' Another of these respondents said, 'I certainly don't want work to be my whole life - I want to have both a home life and life outside the home and to achieve a satisfactory balance between the three. It's easy for work to dominate. There are conflicting demands for one's time. This is one of the factors that made me leave the General Medical unit. I had no time at all - I was on every weekend and every night as well for a couple of years and the situation was intolerable. I'm fairly happy with the compromise I've made between them.'

Secondly, attempts may be made to limit the amount of time spent in work. In the attempt to keep fairly regular hours - to keep at least part of the weekend free of work and to be at home for the evening meal - those activities necessary to the process of carving
out a career in hospital medicine but not immediately essential to patient-care may be curtailed. This course of action, adopted by 11 hospital doctors, represents an ordering of priorities in the allocation of time, a compromise by which the patient is given priority over the family but career goals are circumscribed in the interest of the family.

Thirdly, according to the reports of four hospital doctors, work may be impeded by the fracas of family life. It may prove difficult to work at home because of the difficulty of insulating work from the noise and stress of family life. Similarly, the patient-care may be affected by jadedness consequent on sleep-disturbed nights.

In sum, many junior hospital doctors find that in order to accommodate conflicting demands on their time they must curtail both family and work activity.

WORKLOAD PROBLEMS

The impact of heavy workloads on family life cannot be examined only in terms of consequences for the amount of time spent in familial activity. Such an approach says nothing of the consequences for family life of workload factors other than the total number of hours worked—of factors such as irregularity in the working week, absence from home overnight, or weekend working. It says nothing of the problems that are faced in this situation, and it says nothing of subjective reactions to 'husband-absence', of definitions by husbands and wives of the way in which time ought to be spent.
Respondents' reactions to husband-absence was explored by systematic probing following the question: 'In what ways, if any, has your family life been affected by your/husband's work commitments?'

**Hospital doctors' wives on workload problems**

Workload problems reported by the wives of junior hospital doctors fell into the following categories:

1. difficulties arising from paternal deprivation;

2. difficulties arising from the single-handed management of the household;

3. curtailment of social activity;

4. the problem of loneliness.

Only two doctors' wives felt that there were no problems for family life consequent on their husbands' workloads.

1. **Problems arising from paternal deprivation**

The problems of paternal deprivation were referred to by 17 doctors' wives. These wives feel that, on the one hand, their husbands miss a great deal of a phase that won't recur in the development of their children, and that, on the other hand, their children are growing up in a female environment and are over-dependent on their mothers. Wives have, as one wife put it, to be partly mother and father to their children. They tend to feel that their children, especially the boys, need their fathers' company - that father should be there to play games with them, take them to the zoo, or swimming, and to discipline them when their own attempt at discipline becomes 'just mother going on again' when their voices, shrill with their own frustration, simply go over their children's heads.
Case No. 19, Mother of a girl aged 6, and a boy aged 2: I would like him to have more time to spend with the children and I would like him to have more time so that we could go out as a family to the park and so on. .... is of an age where he could take her to the museum. I take her swimming and I'd like .... to come too but he has often too much work to do or is too tired.

Case No. 8, Mother of 2 boys aged 6 and 4: The children do miss their father if he's not here at home for a bit. If he isn't around at bedtime, they get cheessed off. They complain when Daddy is not at home at weekends when everyone else's Daddy is. I mind when the children mind. If they didn't mind, I don't think it would bother me. In fact, although he is so busy, he plays with them very much. Whenever he is here, he is quite at their disposal. They get quite cross when he goes off. They talk of the hospital as a nasty black place.

What might loosely be described as behaviour difficulties were reported by five wives. A 3\(\frac{1}{2}\)-year-old boy, the son of an obstetrician and gynaecologist, had been sent to nursery school primarily because his mother thought he was becoming a hanger-on-to-of-apron-strings in the absence of an adult male model. The two children of another obstetrician developed a fear of men and could not be left in the care of their father because he was so much a stranger to them. A third wife reported aggressive behaviour, a fourth sleep problems and a fifth schooling difficulties. These problems were attributed to father-absence. It is, of course, possible that they were wrongly so attributed. Wives may sometimes use the children as a vehicle for expressing their own frustrations consequent on husband-absence. The consequences for children may not be the result of father-absence in itself, but of the mother's tensions in a situation of husband-absence.
2. **The problem of single-handed management of the household**

Dislike of a situation in which they were running their household more or less single-handed was expressed by 16 doctors' wives. It would seem that what they find difficult is not so much coping with everyday domestic tasks but particular crises situations such as the arrival of a new baby, illness or physical exhaustion. They particularly feared crises situations occurring when their husbands were away at night – when help is not available from other sources. Further, having sole responsibility for the children may be overwhelming.

**Case No. 7, Mother of two, married for six years:**
I have to do things like decorating and gardening and carpentry and things because he never has the time. Any time he does have he feels he should spend studying. And, of course, I thought with this idea of shared parenthood – but it just doesn't happen with us. The responsibility is trying. Just after... (her younger daughter) was born, was awful. I used to get so tired because... (their older daughter) was about 2. Sometimes he gave her her 11.00 o'clock feed. I very much appreciated it.

**Case No. 9, Mother of a 2-year-old girl, looking back to the time when her husband was preparing for his exams during the year after the birth of their child:** He worked non-stop. He came home, went straight to his study and got up to go to bed. And the fact that he was there and I couldn't rely on him for help made me nervous. After-birth depression made it worse. And I was up most of the night with... (the baby). And... (her husband) couldn't be a help and I didn't and couldn't ask him to help because I knew he had a tremendous amount of work to do. He gave me as much help as he could.

**Case No. 12, Mother of 3 boys, married 8 years:** Just after we bought this house and... was born, ... went off to London leaving me with a new house, a toddler and a baby to cope with. I coped quite well I think but I was periodically depressed. For example, when... had measles and I thought he was terribly ill. And my mother-in-law appeared. She is not a capable person emotionally – she flaps and panics. I did have periodic flashes of I can't cope, said more to myself than anyone else. I never went to my G.P. and I don't think I needed him though I often wished that someone would take over from me, especially when we had the plasterers in doing maintenance for the house and making an awful mess.
If not getting help is problematic, getting help is also problematic in that it gives rise to feelings of guilt. Making demands on already over-worked husbands is regarded as unfair.

Case No. 12, Mother of 3, married 8 years: There is tension about who does what but for the wrong reason. If he does the washing up, I often feel guilty. He does work jolly hard and I feel guilty sometimes because he baths the boys or does the dishes. Yet he enjoys it. He's more sprightly in the morning than I am. Really it's irritating, but I do feel guilty.

Case No. 30, Mother of 3, married 8 years: It's bad for his health (the hours he works). That worries me. And makes me feel guilty when he takes his share of the kids. He does do quite a lot. I am not the sort of wife who likes to keep the children as my department. What tension there is in the direction of my feeling guilty because he's good-natured and does more than he should. But this is in the context of the job which is very demanding. It's not that I feel a husband shouldn't help.

A few doctors' wives felt that the household tended to be disorganised by the irregularity of their husbands' hours of work, an irregularity which produced burnt suppers, non-existent teas and chaotic dinner parties.

Case No. 5, Mother of 2, married 4 years: It would be nice in some ways if he had a 9.00-5.00 job. One would be able to plan in advance more easily. One has one's quotas of dried-up suppers and non-existent teas. It doesn't bother me because I know it's unavoidable - if he's late because of an emergency it's no fault of his, and even if it were there is nothing I could do about it.

On the odd occasion - for example, if we were entertaining and he was late - I would be upset simply because I was banking on him putting the children to bed.
3. The curtailment of social life

Restriction of social activities, reported by 21 doctors' wives, is seen as resulting not only from the number of hours worked but also from the vagaries of the on call system. The fact that husbands may be on call on different nights each week makes it difficult to plan anything in advance as this may fall through and will involve letting down other people. Activities such as evening classes demanding a firm commitment to a particular day of the week are ruled out as husbands cannot be relied upon to babysit. 'It can however be done,' one wife told me. 'For example, earlier this year I went to gardening classes. But it is difficult and you tend to let things drift.'

Several wives in the sample do in fact attend evening classes and doubtless by determined organisation outside activities could be developed to a greater extent than they are.

The period spent in preparing for examinations is particularly restrictive of social activities. During this period social activities drop out almost entirely and couples come to lead what was referred to by one wife as a 'constipated existence', by another as 'being in purdah'.

However, it is not at all certain that work is the key factor in limiting social activity. As several husbands and wives pointed out, they would not in any case be able to get out a great deal either because of baby-sitting problems or because they could not afford a very active social life.
4. The problem of loneliness

Dislike of being alone in the evenings, at nights or at week-ends was referred to by 27 doctors' wives. Judging both by the frequency and intensity with which they spoke about this, loneliness and the problems loneliness brings with it seems to distress wives more than the other problems associated with heavy workloads.

Many hospital doctors are, as one wife put it, 'part-time husbands'. In the period leading up to examinations, evenings may be devoted entirely to study. The picture that emerges is not exactly one of connubial companionship. Doctors retire to their study after the evening meal and emerge only to go to bed. Their spouses sit in the living room, watching television, reading, sewing, knitting or doing the ironing. And when there is no study and only one living room, television-viewing is not 'on'. 'You become part of the furniture, you know,' one wife told me.

Case No. 14: At times I thought he overdid it. The moment he came in he was rushing to the books, tearing through the meal to get on. There was no time to sit back for general discussion. Also his mind was too taken up with medicine to think about anything outside it. I did miss not being able to have any time together to talk over ordinary social events. I did find at times I would have liked to have conversation with someone above baby-talk. I always have plenty to do, but it would have been nice to have had an occasional chat.

The special arrangements which are sometimes made to maximise the opportunity for study may reduce the opportunity for companionship. One hospital doctor repaired to his parents home during the week and his wife and children repaired to her parents home at weekends.
so that he could work undisturbed. Another wife sent her husband off to the hospital to study every evening after he had failed an exam for a second time: 'I wanted him so desperately to be studying although I also wanted him around the house. I got depressed if he wasn't working and I'm the worst person for distracting people - we'd begin talking over supper and a whole hour would be gone before you knew it. I would have been happier if he had been here but basically I couldn't bear the thought of going through it all again. The whole summer would have been ruined.'

Examination time may be difficult. It was variously referred to as 'ghastly', 'a horrible time', 'a black patch'. But husbands are, at least, in the home at this time. The loneliness is greater when husbands are not very much at home either because they are frequently called out or because they are required to sleep in. Because so much of their time is spent within the four walls of a house, in housework and child care, and with little opportunity for talking to anyone other than the children, the butcher, and perhaps, for a few brief moments, the wife next door, wives look forward to their husbands' being at home in the evening, not only for his companionship but as a means of varying their day.

Case No. 23: In his registrar years he was always being called out. He would be popping in and out all the time - he was the one the juniors called in. And he was giving lectures, working on papers when not on ward work either in the library or his office at the hospital, and we could go through a whole week when he was out on some ploy or the other. He was never in - he might as well not have been here - he was like a lodger. It wasn't that I grudged not getting any social life outside the home. I'm not that sort of person. I haven't missed going out to parties. I've just grudged him not being here at home.
Case No. 22: The worst possible time was when he was registrar in a general medical ward when I hardly saw him. For two years, apart from holidays, he didn't have a day or night off. He went in on Saturdays and Sundays. That was dreadful. I don't want to be reminded of it. How he stuck it I don't know. It was shocking. On receiving nights I didn't see him until the early hours of the morning. He was in and out of bed like a yo-yo. I was very angry - it was so unfair. And lonely.

Case No. 12: What I personally miss most is adult company. I used to find it easier to express myself, to talk on an adult level than I do now. I have become much less socially at ease than I used to be. It's ludicrous when you think that I was a model. I think one needs adults which is probably why I am talking too much to you. I don't think that for a long time I've spent so much time talking about what I think and feel to somebody else.

For some wives the unpredictability of their husbands' working hours may add to the difficulty of coping with loneliness.

Case No. 23: It wasn't only that I didn't see him. It was the waiting in suspense, the unpredictability of it, not knowing whether or not I was going to be alone so that I could plan for it that I found difficult. It's the uncertainty that I found annoying. I couldn't say ahead of the day, I shall be free to do something. It was like being in a prison.

Case No. 3: At times when there was extra pressures on, there is conflict, for example, with exams or his being the only bloke on a team of which there are meant to be four, because there is such a narrow line between just getting along and conflicting. With known things, it's just a question of changing your way of life - for example, until exams are over, there's no question about it. It's important for us as a family and for him. You arrange things - you readjust your existence so as to fit in.

It's the unseeable things that are really difficult, the suicide cases, bosses going on holiday and you don't know about it. It's quite difficult to be tolerant of unexpectedly increasing pressures. When he's called out unexpectedly, I am left with the evening I intended to spend with him without something to do. I don't like his being away from home when I am not expecting it.

It is perhaps at weekends that a husband's absence from home is most difficult. Their neighbours have their husbands home for the
traditional Sunday lunch. Their neighbours' husbands are mowing the lawn or cleaning the car. And they are alone. During the week the wife next door is company. But not at weekends. At weekends she and her husband are doing things together. And wives feel they cannot intrude on other families at weekends.

It is not, of course, only absence from home, or even his disappearance to his study, that deprives a wife of the company of her husband. Even when he is at home, she may be effectively deprived of his company because he is too tired to listen or to talk or to do anything but collapse into a somnolent heap on the sofa.

For two wives, their husbands' absence from home presented a rather different problem - a problem of learning to adjust to a husband who was often just not there.

Case No. 14: (Marriage) was slightly spoilt in the first two years by ..... being in hospital. It takes longer to get used to the things that irk. It puts off the time when you are really going to get to know the other person. It was like living in a semi-engaged state for two years, seeing each other two nights a week. And with only two nights, it was too short a time to discuss things. So there were rows. Marriage has improved no end since he stopped living in hospital.

Case No. 36: Particularly after a weekend - when I've had to rely on my own resources because with everybody else having their husbands at home you are on your own - there is a certain strangeness when he gets back. Four days is quite a gap. I don't quite know how to put it, but you have to adjust to each other. Even though he does phone every day when he's on.

Junior hospital doctors on workload problems

From the point of view of husbands heavy workloads may entail, firstly, the deprivation of the emotional satisfactions to be found in intimate familial relationships, secondly, the awareness of imposing a difficult situation on their wives and, thirdly, the deprivation of
leisure activity.35

In talking of the deprivation of family intimacy, junior hospital doctors referred particularly to their limited relationships with their children. Limitations on relationships with children were referred to by 17 doctors, but limitations on relationships with wives were referred to by only six doctors.36 These men feel that they miss out on the pleasures of seeing their children grow up, and are becoming 'shadowy figures' in the background of the lives of their children. Fathers of very young children are disturbed because their children seem scarcely to recognise them; fathers of older children because they are full of vague promises which are never kept, a remote figure locked in a study who must not be disturbed and to whose irregular comings and goings it is difficult for children to acclimatise.

Awareness of the difficulties to which wives are exposed - loneliness, deprivation of social life, the brunt of interrupted nights and family crises - was expressed by 26 doctors. In fact, for many hospital doctors the real problem consequent on heavy workloads arises not from the way in which they are themselves deprived of family life but from their wives' inability or unwillingness to cope on their own. Where wives are sympathetic and tolerant of workloads which intrude on family time, husbands are free to pursue their career goals round the clock. There are for husbands no problems beyond those consequent on exhaustion and the deprivation of relaxing activity, and family life and work rub along together.

Case No. 14: Work would be affected by family life if my wife weren't so tolerant. But she realises that one has to work and accepts this.
There is no conflict because my wife is understanding.

Case No. 27: It is hard on her, but she is uncomplaining, not wishing to obstruct my career.

But in other cases, husbands are aware that their wives may be 'disgruntled', 'resentful' and 'fed up'. In these situations they may be under pressure to reduce their workloads, and the conflict between work and family becomes overt. Hospital doctors see the attitudes of wives to heavy workloads as critical to a career in hospital medicine. Without their support, 'life would be fearful', and 'you would have to quit'. In other words the resolution of the conflict between work and family life depends on wives. Indeed their encouragement may make it easier to get on with work than it would otherwise have been.

The following extracts from interview schedules illustrate the way in which hospital doctors experience work and family as conflicting.

Case No. 18: I am the sort of person who wouldn't let it (family life encroach on work). Work is paramount. I often find myself in a situation where there is a conflict of interest between work and home - but frankly if I say I'll be home for my son's fourth birthday party and an ill baby comes in, you have no option really. The job comes first. It rankles. I don't think I've seen .... (his wife) for a whole evening in the last fortnight. And I saw little of the children when they were at a younger age and I would have liked to see them - to see them developing from babies into children. I missed a whole chunk of their lives. But it doesn't make me bitter. I have been used to it. And I saw it in the families of my relations who were doctors.

Case No. 3: There never was any question in the family but that in any crisis situation the job came first. And if the family were making demands, they could not be met. They do sometimes get a raw deal. The hours are so irregular that the kids never have time to adjust to when Daddy's home and when he isn't. But as they get older I am sure they will acclimatise. And when I am studying for exams the family do take second place and have a miserable existence. But my wife organises things.
Case No. 9: It was the other way round. (Work encroached on family life rather than family life on work). Membership is so important that everything else goes to the wall. The tragedy was that .... (baby daughter) didn't sleep. I would go to bed at 2.00 in the morning and I was unable to take my part in the rota of baby-sitting. It was a physical strain for .... (wife) to have to do this. I think at times she felt like chucking it in. She sacrificed herself I suppose. And she found it pretty lonely. It really boiled down to me coming home and eating and going into my study. And that was all she saw of me until breakfast time next morning.

Case No. 12: So much of the time that we have been married, I have been working very hard either studying or in a job taking a lot of time. And this has rather clouded the issue from the point of view of being able to enjoy marriage in the fullest sense. Family and work conflict. It's a matter of inconvenience to me personally, a question of trying to organise the two sides together. One has common or garden jobs to do about the house which just have to be done - such as cutting the grass, papering a room. And the question arises: do you get on with that or go out with the family. And it's difficult to decide which has priority - to decide what thing or person has priority at a particular time when you don't know when next you'll have any free time.

During this last 6 months I never knew what I was doing from one week to the next, and you would fix up to go to the zoo or something with the children and then something turns up and you can't go. It gives rise to conflict and frustration.

Being married and having a family is an extra commitment. Previously one thought of work on the one hand and leisure on the other and the two never came together. Family and work have of necessity to be more intermingled - the whole organisation of one's life is entangled by a family. I think that when you work as a single man you can choose as to when you work and when you don't. As a family man, you have to make concessions here or there depending on one's overall commitments.

I feel work demands far too much time and energy for too little recompense. Too much is expected to the exclusion of one's family life. This is the great complaint that I have.

Case No. 20: Study time is limited by the need to bath this squad and put them to bed, by the need to help with the family and the desire for continuing contact with them. A bachelor friend of mine says he worked for 17 hours a day when not on call. I might have been more successful in passing exams if I had been able to do this.
Not that I resent my family. I simply resent the system that requires me to devote time to study I would rather spend with the family.

And family life is restricted. For example, I'd have liked to take the boys sledding in the last fall of snow. I'm always making promises like one day we'll do... I never get round to it. I'd like to have a specific family outing every Sunday so that the boys don't find me full of vague promises. They are well aware that they mustn't shout and play games when Daddy is reading. In fact, when Daddy has got his exams has become a Christmas that never comes.

And my wife resents the system - the fact that I am never there to help when she needs help.

*Workload problems in the families of general dental practitioners*

The workloads of general dental practitioners are not, as I have shown, particularly heavy. However, evenings and weekends are invaded by work as a result of the extension of their working day beyond 6.00 and of Saturday morning surgeries. These incursions on family time, my interview data suggests, pose problems for general dental practitioners and their wives similar to those experienced by junior hospital doctors and their wives.

Five dentists' wives' feel that their children do not see as much of their fathers as is desirable. By virtue of the length of his working day, they are in bed when he returns home. In a further three cases this problem is circumvented by keeping the children up, though in one instance this produced a sleepy and ill-tempered baby and thus an ill-tempered mother.

Two dentists' wives complained of lack of help with domestic chores at the critical bathing/evening meal time and with Saturday morning shopping.
Restriction of social activities was complained of by four dentists' wives who felt either that the length of their husbands' working day left little time for going out in the evening or that Saturday morning surgeries limited weekend outings. In the words of one respondent, 'It cramps us down a bit'.

Five dentists' wives reported experiencing loneliness. The extension of the working day beyond 6.00 p.m., in the words of one wife, 'makes the day seem very long'. When husbands return home late, husband and wife have very little time together since 'by the time we have had a meal and cleared up most of the evening is gone'. Further, as in the case of hospital doctors' wives, husbands may return home too tired and exhausted to be companionable. Saturday morning surgeries may also be disliked as depriving them of their husbands' company during the weekend. It is disliked even where dentists have a weekday morning off in lieu when, as one wife wryly admitted, 'I've no right to be annoyed'. This attitude suggests that the weekend is 'sacred': a mid-week morning off work is not regarded as adequate compensation for the loss of some of the weekend.

Most general dental practitioners do not see their workloads as being in any way problematic. On the one hand, none found that the demands of work are such that work activity must be restricted in the interests of family life, and, on the other hand, only 38% found that their workloads occasion familial problems. Some of these men complained of the restriction of familial and leisure activity by either Saturday morning surgeries or late evening work, and of their wives as 'binding'. However, their discontents seemed to centre on the exhaustion consequent on working long hours. Most dentists feel
that dentistry involves an unusual degree of physical and nervous strain - that their physical and mental energies are taxed by the intensity of concentration needed, the pace at which they must work and the apprehensiveness of patients.

Yet, although some dentists and their wives experience, in some measure, the workload consequences experienced by doctors and their wives, they do so less frequently. Table 6:9, which presents a comparison of the frequency with which junior hospital doctors, general dental practitioners and their wives report each type of problem, makes this clear.

Further, problems in dentists' families are on a smaller scale than in doctors' families. Their situations are in fact markedly different. Firstly, dentists' workloads are by no means as heavy as doctors' workloads. Secondly, their working week is predictable. Thirdly, it does not involve absence overnight from home. Fourthly, most dentists go home for lunch. As a result, children see their fathers at lunch-time even where they do not see him in the evenings and the tedium and loneliness of the day is broken for wives. Fifthly, by virtue of the control dentists exercise over their working situation, last appointments or Saturday morning appointments may, on occasion, be cancelled in the interests of leisure or familial activity.

Thus work and family life 'mesh' fairly easily for the general dental practitioner and his family, but 'clash' for the junior hospital doctor and his family.
TABLE 6:9 FAMILY PROBLEMS OCCASIONED BY HEAVY WORKLOADS FOR JUNIOR HOSPITAL DOCTORS, GENERAL DENTAL PRACTITIONERS AND THEIR WIVES

<table>
<thead>
<tr>
<th>Problems mentioned</th>
<th>Doctors' Wives (n = 38)</th>
<th>Dentists' Wives (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Paternal deprivation</td>
<td>48</td>
<td>31</td>
</tr>
<tr>
<td>2. Household management</td>
<td>42</td>
<td>13</td>
</tr>
<tr>
<td>3. Restriction of social activity</td>
<td>55</td>
<td>19</td>
</tr>
<tr>
<td>4. Loneliness</td>
<td>71</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems mentioned</th>
<th>Doctors (n = 38)</th>
<th>Dentists (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Deprivation of familial intimacy</td>
<td>47</td>
<td>13</td>
</tr>
<tr>
<td>2. Restriction of social activity</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>3. Awareness of wives' difficulties</td>
<td>68</td>
<td>25</td>
</tr>
</tbody>
</table>

Since some respondents named more than one problem, total % may be more than 100%.
STRATEGIES FOR THE RESOLUTION OF WORKLOAD PROBLEMS

The heavy workloads found in hospital medicine generate, as I demonstrated in the foregoing section, problems for family life. However, these problems may be tempered by the adoption of various strategies. These strategies - like the strategies adopted for tempering the disjunction between income-earning potential and family consumption demands - may be identified and categorised as:

A. Individual strategies: action taken by the hospital doctor or his wife acting as individuals and working within the occupational situation. These strategies involve the adaptation of family patterns to the occupational system.

B. Evasive strategies: strategies aimed at circumventing the problem.

C. Collective strategies: action taken by hospital doctors acting in concert for the improvement of their conditions of work. These strategies are aimed at modifying their occupational situation.

A. Individual strategies

Individual strategies for tempering the consequences of heavy workloads for family life include:

1. the development of family rituals;
2. the use of alternative sources of help and companionship by wives;
3. curtailment of non-familial leisure by husbands.

1. Family Rituals

The development of rituals is not as common as might be expected - the irregularity of working schedules prevent ritualisation. However,
rituals do exist. Wives may 'save up' demanding household chores or such tasks as hair-washing, or letter-writing for weekends or evenings when husbands are on duty so as to have something to do. A particular time may be set aside for the children. Bath-time and bed-time, for example, may also be time with father and the ordinary business of daily living is transmuted by the spirit of family solidarity. To facilitate this, children may be kept up late. At the same time, hospital doctors may, insofar as is possible, so organise their day that work is allocated to those hours of the day when it will least interfere with family life. To this end, they may begin their working day at an early hour, or work through their lunch hour and curtail the amount of time spent in coffee breaks on the wards.

2. Alternative sources of help and companionship

Wives may attempt to provide themselves with alternative sources of help and companionship.

a) Outside interests, such as evening classes, or hobbies such as reading, sewing or knitting, or even television-watching may be taken up. The possibility of taking up outside interests is however limited by the availability of baby-sitters.

b) Friends or relatives in the neighbourhood or another adult person living in the house may provide companionship and emotional support. The parental home can be - and is - returned to when husbands are away overnight. Contact with the outside world is - as two wives found - facilitated by having their own car.
c) Loneliness may be mitigated by working. Three wives were planning to return to work for this reason and three wives had, in the past, taken part-time jobs as a solution to the problem of loneliness. Several wives said that when they were working prior to the arrival of children and at what was often the most critical time in their husbands' careers, they had not found their husbands' involvement in work problematic - they were in contact with people throughout the day and catching up with chores in the evening.

d) Nursery schools are used by some wives as a means of providing their children with contact with adults other than themselves and of off-loading some of the responsibilities of child care.

e) Domestic chores are not often off-loaded onto outside help. Only eight medical wives employed a charwoman. Relatives and friends are used for babysitting, but are rarely used for help with domestic tasks or in child care.

3. Curtailment of non-familial leisure

Husbands may curtail non-familial leisure activity so as to be able to devote as much time as possible to work and to the family. This reduction of non-familial leisure means that the family does not bear the full brunt of heavy workloads.

B. Evasive strategies

Junior hospital doctors may seek to avoid heavy workloads, and attendant problems, by the career paths they choose to pursue. As I suggested in dealing with the way in which hospital doctors see
their worklife as affected by family commitments, some junior hospital doctors may enter those branches of hospital medicine that are perceived as relatively undemanding of time and energy.\textsuperscript{47} This course of action is, in effect, a strategy whereby workload problems are avoided (or at any rate reduced).

C. Collective strategies

The collective action resorted to by junior hospital doctors through, for example, the Junior Hospital Doctors Association, was described in Chapter IV. Therefore, I need here only reiterate that this action is aimed not simply at modifying the structure of opportunity in hospital medicine so that incomes and opportunities for advancement to consultant status may be improved but also at improving their workload situation. To this end, the objectives of the J.H.D.A. include:

1. limitation of hours of work;
2. securing adequate ancillary help so that hospital doctors may be freed from routine clerical work;
3. improving accommodation for compulsorily resident doctors, particularly for married doctors (so as to avoid the separation of husbands and wives that residence in hospital often means).

As I have already mentioned, J.H.D.A. activity for improving working conditions in hospital medicine has effected the introduction of a system of overtime payments for on call duty in excess of 102 hours per week. Further, the Hospital Junior Staffs Group Council, which gained power to negotiate directly with the Departments of Health as a result of J.H.D.A. activity, is currently negotiating a
new standard contract aimed at securing, inter alia, a reduction
in hours of work, more extensive study leave and action on hospitals
where residential accommodation is below standard.48

ATTITUDES TO HEAVY WORKLOADS

Attitudes to 'overtime' working are different from attitudes
towards income rewards and geographical mobility. Where income
rewards and geographical mobility are concerned, most wives, as I
have shown, subscribe to values which support the absolute priority,
the paramount importance of occupational aspirations. Most husbands
also regard as legitimate work-occasioned mobility, but are caught in
a conflict situation between their desire for job satisfaction and
for income rewards. But 'overtime' working is accorded a 'hedged'
legitimacy by both junior hospital doctors and their wives and is
generally regarded as illegitimate by general dental practitioners
and their wives. This is shown by the views of respondents on the
following hypothetical situation:

I would like you to tell me what you think of this couple,
John and Mary. They have been married for seven years.
They have two children. John who is very involved with
his work, brings work home most evenings and weekends.
Mary complains that she is very much on her own. What do
you think of this couple?

The pattern of responses is shown in Table 6:10.

Most junior hospital doctors and their wives say that in such
a situation there must be 'give and take' and 'compromise'. Careers
are important. It is important that a man should not only be able
to achieve his occupational aspirations in terms of income and status
but that his work should also be satisfying. So, if his job necessitates evening and weekend work, then evening and weekend work must be accepted. Wives ought to share their husbands occupational aspirations.

But marriage and family life are also important. Consequently, occupational aspirations should not be pursued to the exclusion of the family, for, in the words of one wife, 'if a man becomes so wrapped up in his work that he has not time for his wife and family, it is hard on her. She would become really lonely.'

<table>
<thead>
<tr>
<th>Respondent thinks</th>
<th>Doctors</th>
<th>Doctors' Wives</th>
<th>Dentists</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be give and take</td>
<td>47</td>
<td>66</td>
<td>19</td>
<td>31</td>
</tr>
<tr>
<td>Husband should have wife's unqualified support</td>
<td>16</td>
<td>8</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Evening/weekend work intolerable except perhaps in the short term</td>
<td>32</td>
<td>18</td>
<td>56</td>
<td>50</td>
</tr>
<tr>
<td>Response not classifiable</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL %</td>
<td>100</td>
<td>100</td>
<td>101</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>33</td>
<td>33</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>
So, because work is important, the hypothetical John's wife should accept a situation in which he brings work home and should develop outside interests so as to obviate the problems of loneliness and boredom. But because family life is also important he should devote some attention to the family. He should bring home less work and she should be more understanding.

Both husbands and wives tend to feel that it is partly a question of attitudes - of a husband making some gestures which show that he recognises that his wife exists and needs him and that he needs her. In the words of one hospital doctor, 'There is all the difference between a husband who simply works all evening and then goes to bed and a husband who works all evening but spends half an hour talking to his wife before going to bed'. Or in the words of a doctor's wife, 'Working in the evenings is all right so long as he wants to spend some time with his wife. That is the point. Even if he snatchers only one night a week.' Or in the words of another wife, 'It would be wrong if he were simply to disappear immediately on coming home, but if he sat in the same room with her and worked while she did some sewing or had a drink with her first, then it would be all right. He is after all in the same house with her.'

This give-and-take attitude is characteristic of most hospital doctors and their wives. Only a third of hospital doctors and very few of their wives seem to be basically hostile to 'overtime' working. By contrast general dental practitioners and their wives tend to be hostile to 'overtime' working. Dentists and dentists' wives feel that evening and weekend work is intolerable, except perhaps for short periods for, for example, the acquisition of qualifications. In their view, no job is so important.
and no worker so hard pushed that work should be allowed to intrude on family and leisure time. The hypothetical John is 'overdoing it'. Overtime work should not be necessary for it should be possible to so organise one's work that it takes place within the confines of a normal working day. At the same time, family life is too important to be eroded by work in this way. 'You have got to spend a lot of time together as companions otherwise you drift apart very quickly. And if you resent your husband doing this, tension builds up very quickly.' Overtime work is seen as 'bad for the marriage in the end'. 'Life is not really worth living at that pace for there is more to life than achieving the ultimate.'

In sum, general dental practitioners and their wives subscribe to the view that 'overtime' work is illegitimate, but junior hospital doctors and their wives generally accord 'overtime' work a 'hedged' legitimacy.

The fact that 'overtime' working is seen as illegitimate by general dental practitioners and their wives and is accorded only a hedged legitimacy by junior hospital doctors and their wives suggests that 'overtime' working is experienced as more stressful and seen as more detrimental to family life than income-earning potential or geographical mobility, both of which are accorded a greater degree of legitimacy.

Further, there is obviously potential for conflict over the establishment of boundary lines between legitimate and illegitimate working time. Where husbands and wives do not share the same definition of the appropriate boundary lines between legitimate and illegitimate 'overtime' work, then we may expect the structured tensions that exist
between work and family (as a result of their competing demands for a man's time) to be accompanied by stress at the personality level and, possibly, by husband-wife conflict.

Yet, as in the case of the response to geographical mobility and to the disjunction between the structuring of earning power and family consumption patterns, the interview data seems to suggest that some wives experience considerable distress on the personality level as a result of problems consequent on heavy workloads, while others do not. I now turn to the examination of this phenomenon.

APPENDIX: Measuring the amount of time spent in work, familial and non-familial activities.

In order to find out how much time was spent in work and in non-work activities, respondents were asked to keep a diary for the week following the interview. They were given a pro forma schedule which listed various work, family and leisure activities and were asked to state, for activities engaged in, the time at which they began and the time at which they finished these activities, and whether they performed these activities with their spouse, children, relatives, neighbours, friends and/or colleagues.

The activities husbands were asked to time fell into three main categories:

A. Work activities;
B. Family activities;
C. Non-familial leisure activities;

A. Work activities covered:
1. the working day;
2. working away from home in the evenings or at weekends (that is at the hospital or surgery or attending lectures or meetings in any way connected with work);
3. working at home in the evenings or at weekends (including reading work-associated literature).

Travelling time was included in the working day. Lunch was also included where respondents lunched with colleagues within their place of work. It is worth noting that there is a marked difference between junior hospital doctors and general dental practitioners in their lunching habits. Most dentists returned home to lunch on most days of the week, whereas only eight hospital doctors lunched with their families at all, and that only for a total of 13 days. In general, the dentists' 'lunch hour' was 1½ hours. The doctors' 'lunch hour' was, in general, less than ½ hour. Sometimes they did not lunch. One respondent told me that, theoretically, he was entitled to an hour for lunch but that, in practice, his lunch hour was eaten into by clinics that over-ran, letter-writing, and meetings. Another respondent noted that he usually snatched a pie in the operating theatre, and another that he had sandwiches and coffee in a poky little room for about 15 minutes. Only four hospital doctors recorded lunch hours of 1 hour or more. The very different lunch time patterns of dentists in general practice and junior hospital doctors is probably due as much to differences in their working milieu as to the pressures and demands of their working situation. The hospital doctor works with numerous colleagues, the dentist on his own or with one/two colleagues. The hospital doctor's working milieu is provided with canteens and facilities for coffee and sandwiches. The dentist's is not.
Where a recorder was away on the job overnight, as when doctors slept overnight in hospital, the working day was arbitrarily treated as being 14 hours long and the rest of the day was assigned to the category reserved for sleep and for time spent in physical care of the self. Being on call from home was not treated as work (unless, of course, the respondent was actually called out). Through an oversight, respondents were not asked to record the amount of time spent in telephonic communication with the hospital when on call.

B. **Family activities covered:**

1. **Participation in domestic tasks:** this sub-category was made up of the following activities: helping get meals, helping clear up after meals, gardening, doing things about the house (for e.g. repairs, painting and decorating);

2. **Interaction with the children:** this sub-category was made up of the following activities: helping get the children up and dressed, helping get the children ready for bed, playing with the children, family outings including the children, such as swimming, a run in the car, visits to relatives;

3. **Home leisure activities:** this sub-category was made up of watching television, listening to music, reading, talking with wife, any other home leisure activity or hobby;

4. **Social activities:** this sub-category was made up of the following activities: entertaining or visiting, going to the theatre, cinema, or a concert or participating in any other cultural activity,
participation in a sport, having dinner in a restaurant, going to a party or dance, taking part in a political, church, civic or social welfare activity, where these activities were engaged in by husband and wife together.

C. Non-familial leisure activities

This category included entertaining or visiting, going to the theatre, cinema or a concert or participating in any other cultural activity, participating in a sport, having dinner in a restaurant, going to a party or dance, taking part in a political, church, civic or social welfare activity where these activities were engaged in by husbands unaccompanied by their wives.

All time not recorded as having been spent in work, family or non-family leisure activities, was assigned to a residual fourth category. This category included time spent in meals, other than mid-day meals taken in a place of work which were defined as a work activity, and evening and weekend meals taken with relatives, friends or colleagues which were defined as a social activity. It also included time spent in sleep, physical care of the self and other non-recorded activities.

Wives were asked to record, during the week for which their husbands were keeping diaries, the amount of time they spent in family activities and in non-familial leisure.

Diaries were kept and returned to me by all of the 16 dentists and their wives and by 34 of the 38 hospital doctors and their wives.
One doctor was not asked to keep a diary as he clearly regarded the interview as over-long. The other three doctors, though they had agreed to keep the diaries, evidently drew the line at doing so. This means that estimates of the amount of time spent by doctors in work, family activity and in non-familial leisure is based on a sample size of 34.

**Limitations**

The diary method is not without its limitations. Firstly, there is considerable variation in the precision and accuracy with which the diaries were kept. Some diaries were obviously kept very carefully and on a daily basis. Others, equally obviously, had not been. There are time gaps between recorded activities. The people with whom an activity was engaged in are not always recorded. There are sometimes discrepancies between husbands' and wives' records of their day. But although the diaries are by no means a wholly accurate account of the recorder's week, and although there is considerable variation in the precision with which they were kept from recorder to recorder, they do provide a continuous account of the way in which these men and women spend their time. Further, the diary record is more likely to be accurate and is certainly more precise than respondents' recollection of how they spent the week preceding the interview would have been.

Secondly, the assignment of activities to one rather than another category is sometimes arbitrary. For example, time spent in helping put the children to bed could readily be categorised either as participation in domestic chores or as interaction with the children.
Family outings which include the children could have been classified as social activities. Not all the time spent at work is time spent working - some of it is spent in social interaction with colleagues or other members of staff. In such cases, the assignment of activities to one category rather than another can only be arbitrary.

Thirdly, the diaries provided a record of how hospital doctors and dentists in the sample spent their time during one particular week. But the way in which they spend their time probably varies to some extent from week to week, and from season to season.

Fourthly, the diary records have almost certainly been contaminated by the preceding interview. Indeed two wives added notes to their diaries indicating that this had in some ways been an unusual week for them - one noted that her husband had taken her out to dinner, the other that her husband had looked after the children so that she could go shopping. As respondents exhibited, during the interviews, considerable sensitivity over what they thought to be the poverty of their social lives, it seems particularly likely that the amount of time spent in familial and non-familial social activities has been artificially inflated. The amount of time spent in interaction with children may also have been inflated by sensitivity over parental roles. However, the extent to which respondents can cheat is limited - they have not got a great deal of time for manoeuvre. The day is only 24 hours long and most of this 24 hours is necessarily spent in work and in sleep and other essential activities such as eating and dressing. The extent to which the total amount of time spent in family activities can be over-recorded is, therefore, limited. Time wrongly assigned to one family activity will generally be assigned to this activity at the expense of another family activity.
Finally, a time-budget provides no clue as to the importance which the recorder attaches to the activity he engages in. It is merely a record of the amount of time spent on specified activities.

Nevertheless the diaries do provide a record of how these doctors and dentists spent a week of their lives and, within the context of the present study, a record of the intrusion of work into what might normally be regarded as family or leisure time.
The influence of occupational aspirations on workloads

The foregoing analysis seems to suggest that the workload of the junior hospital doctor is to a considerable extent constrained by his occupational situation, while the general dental practitioner is relatively free from situational constraints and is therefore able to choose for himself that balance between workload and income which seem to him to be desirable.

This is, however, an oversimplification. For beyond a certain point the workload of the junior hospital doctor is - like his mobility and his earning power - shaped not only by his occupational situation but also by the aspirations he brings to the workplace and the place work plays in his life-plans. Career decisions are made in the light of these aspirations.

Thus, although all hospital doctors are committed, by virtue of the career structure of hospital medicine, to examination-passing, research and publication, aspirations influence the amount of time spent in these activities. The hospital doctor who is ambitious for a professorial chair will spend more time in such activities than the doctor who is not. Similarly, dentists who are committed to maximising their income will spend more time working than dentists who are not.

At the same time those for whom work is self-expression and self-fulfilment are likely to spend more time on the job than those
CHAPTER VII

The Tension Between Work and Family

THE ARGUMENT SO FAR

There are, I have demonstrated, situationally-structured conflicts between the occupational system of hospital medicine and the family system. Firstly, income rewards are low and tenure of office insecure during the family building phase of the life-cycle when demands on financial resources are heavy. Secondly, geographical mobility frequently uproots the family. Thirdly, workloads limit involvement in family life. As a result, hospital doctors and their families are beset by diverse problems.

By contrast, the conditions under which the occupational role of general dental practitioner is performed are structurally compatible with the performance of the husband-father role. In dentistry income rewards are high and occupational position secure throughout the life-cycle. Careers are facilitated by the geographical stability which seems to be in the best interests of family life. Regular and relatively light workloads are compatible with active involvement in family life.

However, the values and aspirations hospital doctors bring to the workplace must also be taken into account. As I have shown, hospital doctors are bent on a search for intrinsic job satisfactions - their high valuation of self-fulfilment in work and relatively low valuation of income and security rewards is evidence of this. It is because of this orientation to work that they have chosen hospital medicine rather than general practice and have thus placed themselves in a situation in
which they will experience low earning power during the home-making and family-building stage of the life-cycle, geographical mobility and heavy workloads.¹

Given this, and given that in general hospital doctors seem to find their work rewarding, structured incompatibilities between work and family are not necessarily experienced as distressing on the personal level.² Particular patterns of mobility and particular workload patterns seem to be accepted as the corollary of career aspirations and are either not experienced as problematic or are experienced as problematic only as a result of their wives' reactions. The response to economic rewards is more variable. Some hospital doctors seem to have a puritan disregard for the creature comforts of this world and thus do not experience the disjunction between the pattern of economic rewards in hospital medicine and the cycle of family consumption demands as distressing. But others aspire both to material well-being and to self-fulfilment in work, and these men experience their conditions of service as distressing.

The values and aspirations of wives must also be taken into account. Marriage to a hospital doctor implicitly constitutes a decision to accept the life-style which accompanies his occupational career. This may be inferred from the fact that wives frequently say that low incomes, mobility and heavy workloads were expected. By the same token, hospital doctors when marrying seem to assume that their brides know what is involved and have, in deciding to marry them, accepted all that is involved.³ They frequently stressed the importance of choosing the right wife; and of communication and explanation before and after marriage.
Moreover, most doctors' wives, like their husbands, seem to believe, as I have shown, that self-fulfilment in work is very important and is, indeed, essential to a man's happiness. Believing this, they also believe that the integrity of the home depends on the husband's occupational happiness and success, and that wives must therefore accord priority to career aspirations and accept the life-style that flows from a chosen career path. They thus legitimate the income-earning situation of their husbands, geographical mobility and, within limits, heavy workloads.

This set of attitudes would seem to explain the fact that many wives do not experience the situationally-structured tensions which exist between work and family in hospital medicine as distressing. That they do not do so is clear from the calm, matter-of-fact way in which they spoke of the problems experienced. And indeed some wives denied finding either low incomes, geographical mobility or heavy workloads problematic.

But situationally-structured tensions between work and family are experienced as distressing by some wives - as evidenced by their use of emotional language to describe their experiences, their tone of voice, gestures and facial expressions.

The fact that the situationally-structured conflict between work and family is experienced as distressing by some wives but not by others requires explanation. It is to this problem that this chapter is devoted.
THE EXTENT OF DISTRESS REACTIONS AMONG WIVES TO SITUATIONALLY-STRUCTURED WORK–FAMILY TENSIONS

I attempted to assess the extent to which the structured conflict between work and family is experienced as distressing by examining the interview material for the presence/absence of negative feelings towards the problems occasioned by low income, geographical mobility and heavy workloads. The expression of negative feelings - that is the expression of anxiety, hostility, resentment or indignation and the use of highly emotional phrases such as 'I hate it, I really do' - was taken as indicating that structured conflicts are experienced as tension-producing on the personality level. The absence of negative feelings was taken as indicating that structured conflicts are not experienced as stressful. Vocal expression (intonation) was taken into account in making judgements as to the presence of negative feelings.

By this measure nearly two-thirds of junior hospital doctors' wives were found to be experiencing distress as a result of structured work-family tensions of any type (Table 7:1 (a)). Workload problems appear to be the major source of distress. Further, Table 7:1 (b) shows that there is some tendency for financial and mobility problems to be experienced as distressing only by wives who also experience workload problems as distressing. This suggests that distress reactions both to low earning power and to mobility may be linked with distress reactions to high workloads.

A quantitative measure of the distress occasioned by structured work–family conflict was also obtained by asking wives: 'Would you say that you are sympathetic to how your husband feels about work?'
TABLE 7:1 (a)  INCIDENCE OF PERSONAL DISTRESS OCCASIONED BY SITUATIONALLY STRUCTURED WORK-FAMILY TENSIONS AMONG WIVES OF JUNIOR HOSPITAL DOCTORS

<table>
<thead>
<tr>
<th>Source of distress</th>
<th>Distress high</th>
<th>No Distress low</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Financial problems</td>
<td>16</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td>Mobility problems</td>
<td>29</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td>High workload problems</td>
<td>47</td>
<td>53</td>
<td>100</td>
</tr>
<tr>
<td>Financial or mobility or workload problems</td>
<td>63</td>
<td>37</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 7:1 (b)  INCIDENCE OF PERSONAL DISTRESS OCCASIONED BY COMBINATIONS OF SITUATIONALLY STRUCTURED WORK-FAMILY TENSIONS AMONG WIVES OF JUNIOR HOSPITAL DOCTORS

<table>
<thead>
<tr>
<th>Source of distress</th>
<th>% of distressed wives (n = 38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial and mobility problems</td>
<td>5</td>
</tr>
<tr>
<td>Financial and workload problems</td>
<td>11</td>
</tr>
<tr>
<td>Mobility and workload problems</td>
<td>13</td>
</tr>
<tr>
<td>Financial, mobility and workload problems</td>
<td>5</td>
</tr>
<tr>
<td>Financial problems only</td>
<td>5</td>
</tr>
<tr>
<td>Mobility problems only</td>
<td>11</td>
</tr>
<tr>
<td>Workload problems only</td>
<td>24</td>
</tr>
</tbody>
</table>
The patterning of responses to this question supports the evidence of the incidence of distress provided by the expression of negative feelings towards structured work-family conflicts. Forty-seven per cent of wives (compared with 37% of wives categorised as not distressed by any work problem) are very sympathetic. Forty-two per cent are sympathetic and 11% are fairly sympathetic or not particularly sympathetic (that is 53% of wives are, in some measure, out of sympathy with their husbands' feelings about work while 63% of wives were categorised as distressed by work problems). Further, as Table 7:2 shows, those wives who are not very sympathetic with their husband's feelings about work are, for the most part, the wives who expressed negative feelings about structured work-family incompatibilities. This statistical relationship is corroborated by the reasons volunteered by some wives for being other than very sympathetic.

**TABLE 7:2**  THE RELATIONSHIP BETWEEN SYMPATHY FOR HUSBANDS' WORK ATTITUDES AND EXPRESSION OF NEGATIVE FEELINGS ABOUT STRUCTURED WORK-FAMILY TENSIONS AMONG HOSPITAL DOCTORS' WIVES

<table>
<thead>
<tr>
<th>Sympathy for husbands' feelings about work</th>
<th>Wives expressing negative feelings</th>
<th>Wives not expressing negative feelings</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage (%)</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Very sympathetic</td>
<td>45 +</td>
<td>55</td>
<td>100 18</td>
</tr>
<tr>
<td>Not very sympathetic</td>
<td>80</td>
<td>20</td>
<td>100 20</td>
</tr>
<tr>
<td>TOTALS</td>
<td>63</td>
<td>37</td>
<td>100 38</td>
</tr>
</tbody>
</table>

+ Four of these wives were seen as not very sympathetic by their husbands. This tends to support the classification of these wives as experiencing negative feelings about work-generated family problems. Of the remaining four, 3 were classified as experiencing distress on one count only.
Distress occasioned by work-family incompatibilities as a factor in marital disharmony

The inability of wives to tolerate with equanimity structured tensions between work and family may lead to husband-wife conflict. This is evident from the accounts of both husbands and wives of family problems occasioned by work which told of quarrels, bitterness, recrimination and resentment. Quantitative evidence of the extent to which the distress experienced as a result of work-occasioned problems may lead to marital discord is provided by the statistical relationship I found between wifely lack of sympathy with husband's feelings about work and marital dissatisfaction. As Table 7:3 shows, wives who are not very sympathetic with their husbands' feelings about work are more likely to be dissatisfied with their marriage than wives who are very sympathetic with their husbands' feelings about work. Similarly, hospital doctors who perceive their wives as not very sympathetic with their attitudes about work are more likely to be dissatisfied with marriage than those who believe their wives to be very sympathetic.

In short, structured work-family tension, when experienced as distressing by doctors' wives, may be a factor in marital disharmony.

Distress occasioned by work-family tensions among dentists' wives

The wives of general dental practitioners are far less likely than the wives of junior hospital doctors to experience distress as a result of structured work-family conflicts (Table 7:4). This is hardly surprising given the limited nature of the consequences of general dental practice for family life. As I have shown, dental practice does not
TABLE 7:3  THE RELATIONSHIP BETWEEN SYMPATHY FOR HUSBANDS' WORK ATTITUDES AND MARITAL SATISFACTION IN HOSPITAL MEDICINE

<table>
<thead>
<tr>
<th>Sympathy for Husbands' feelings about work</th>
<th>Satisfaction with marriage</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wives are very satisfied</td>
<td>Wives are not very satisfied</td>
<td>Totals</td>
<td>percentage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Wives are:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>very sympathetic</td>
<td>78</td>
<td>22</td>
<td>100</td>
<td>18</td>
</tr>
<tr>
<td>not very sympathetic</td>
<td>55</td>
<td>45</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>66</td>
<td>34</td>
<td>100</td>
<td>38</td>
</tr>
</tbody>
</table>

Husbands are very satisfied  Husbands are not very satisfied

2. Husbands perceive Wives to be:

|                                          |                           |                           |         |            |   |
|                                          | Wives are very satisfied  | Wives are not very satisfied | Totals | percentage | n |
|                                          |                           |                           |         |            |   |
| very sympathetic                        | 74                        | 26                        | 100     | 23         |   |
| not very sympathetic                    | 47                        | 53                        | 100     | 15         |   |
| Totals                                  | 63                        | 37                        | 100     | 38         |   |

consume family time. It does not expose the family to the risk of moving house at fairly frequent intervals. It affords a high standard of living even during the early stages of the family life-cycle. In fact it is surprising that as many as 25% of dentists' wives experience distress as a result of workload factors, given the very limited impact of the time demands of dentistry on family life. This finding again
<table>
<thead>
<tr>
<th>Structured work-family conflict occasioning distress</th>
<th>Doctors' Wives</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Distress</td>
<td>Distress</td>
</tr>
<tr>
<td>Financial problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td>Mobility problems</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>High workload problems</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>% of sample distressed</td>
<td>63%</td>
<td>37%</td>
</tr>
</tbody>
</table>
points to the fact that 'overtime' working is particularly likely to be problematic for family life.

Yet, in spite of the absence of structured work-family tensions, dentists' wives are not as sympathetic as doctors' wives towards their husbands' feelings about work. This is shown in Table 7:5. Further, dentists more frequently than hospital doctors see their wives as being other than very sympathetic with their attitudes to work (Table 7:6).

This lack of sympathy seems to be caused not by the demands that the dentist's occupational role makes on his wife but by his dissatisfactions with work. This is suggested by the reasons volunteered by wives for their lack of sympathy with their husbands' work attitudes. Their comments suggest that they are not very sympathetic with their husbands' complaints about the public's attitudes to their teeth, their fears of dentists, their unpunctuality; about the strains imposed on the dentists by the way in which dental practice is organised under the National Health Service; about the threats to their health posed by the practice of dentistry; about the performance of their chairside assistants and receptionists; about the contentious behaviour of their colleagues and principals.

In sum, it would seem that wives in these two occupational groups are more likely to sympathise with their husbands' feelings about work, their goals and aspirations when they are contented than when they are discontented with work. They are more likely to do so even though greater demands may be made of them in terms of living standards, mobility experience and husband-absence.
### Table 7:5

**A Comparison of the Sympathy Felt by Wives of Junior Hospital Doctors and by Wives of General Dental Practitioners for Their Husbands' Feelings About Work**

<table>
<thead>
<tr>
<th>Wives are:</th>
<th>Doctors' Wives</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Cumulative %</td>
</tr>
<tr>
<td>fairly sympathetic</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>sympathetic</td>
<td>42</td>
<td>55</td>
</tr>
<tr>
<td>very sympathetic</td>
<td>47</td>
<td>100</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>

### Table 7:6

**A Comparison of the Perception by Junior Hospital Doctors and General Dental Practitioners of Their Wives as Sympathetic to Their Feelings About Work**

<table>
<thead>
<tr>
<th>Wives are perceived as</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Cumulative %</td>
</tr>
<tr>
<td>fairly sympathetic</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>sympathetic</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>very sympathetic</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>
However, dentists' wives lack of sympathy with their husbands' occupational discontents does not seem to be associated with marital discontent. Though most wives are not very sympathetic with their husbands' feelings about work, and are perceived as not very sympathetic by their husbands, very few dentists' wives and very few dentists, think that their marriages are not going well (Table 7:7). As a corollary of this, there is greater marital satisfaction among dentists and their wives than among hospital doctors and their wives.

### TABLE 7:7 SATISFACTION WITH MARRIAGE AMONG JUNIOR HOSPITAL DOCTORS, GENERAL DENTAL PRACTITIONERS AND THEIR WIVES

<table>
<thead>
<tr>
<th></th>
<th>Doctors %</th>
<th>Cumulative %</th>
<th>Dentists %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>fairly satisfied</td>
<td>11</td>
<td>11</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>satisfied</td>
<td>26</td>
<td>37</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>very satisfied</td>
<td>63</td>
<td>100</td>
<td>73</td>
<td>100</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>38</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Doctors' Wives %</th>
<th>Cumulative %</th>
<th>Dentists' Wives %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>fairly satisfied</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>satisfied</td>
<td>32</td>
<td>34</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>very satisfied</td>
<td>66</td>
<td>100</td>
<td>87</td>
<td>100</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>38</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>
We may therefore conclude that the irritation that dentists' wives feel with their husbands' job dissatisfactions and dentists' perception of this irritation is not sufficient to lead to marital disharmony. But the distress generated by structured work-family disharmony among hospital doctors and their wives may be so strong as to generate marital disharmony. This finding is of critical importance for it suggests the hollowness of the ideology - based on the importance of job satisfaction to the personal happiness of husbands and therefore to marital happiness - by which the encroachment of work on family life is legitimised by hospital doctors and their wives. Dentists and their wives are satisfied with their marriages despite the fact that dentists are not happy in their work and despite their wives' lack of sympathy with their occupational discontents.

THE EXPLANATION OF HIGH LEVELS OF PERSONAL DISTRESS

In sum, some hospital doctors' wives experience situationally-structured work-family tensions as distressing and some do not. Distress is experienced even though attitudes tend to legitimise the workings of the occupational system and the pursuit of intrinsic satisfaction in work, and despite the fact that hospital doctors have chosen to enter hospital medicine, and their wives have chosen to marry hospital doctors, decisions which presumably imply a tacit acceptance of the conditions of work of hospital medicine. This varying degree of personal distress generated by situationally-structured work-family tensions requires explanation.
On the basis of explanations advanced by respondents themselves and/or deductive reasoning, the following factors were investigated as likely to provide an explanation, or a partial explanation, of the different levels of distress experienced by wives of junior hospital doctors:

1. variations in workload;
2. variations in family size;
3. variations in degree of mobility;
4. expectations of marriage;
5. medical background of wives.

The first three of these factors relate to variations in the intensity of the objective pressures to which wives are subjected. That is, in investigating the relationship between experienced distress and variations in workload, family size or mobility, one is, essentially, suggesting that the intensity of personal distress is determined by the objective intensity of situationally-structured work-family tensions. But in investigating the medical background of wives (and thereby the set of expectations which may be presumed to go with that background) and the marriage expectations of wives, one is suggesting that stress reactions to situationally-structured work-family tensions are determined by the way in which wives define their situation.

1. Variations in workload

The relationship between workloads (as measured by number of hours worked during the week for which respondents kept a diary) was examined on the hypothesis that distress is likely to increase
when pressures increase, that is when workloads exceed 60 hours, the point at which participation in family life seems to be seriously affected. However, no relationship was found between workload pressures and distress (Table 7:8).

<table>
<thead>
<tr>
<th>Workloads</th>
<th>Distress</th>
<th>No Distress</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Over 60 hours</td>
<td>56</td>
<td>44</td>
<td>100</td>
</tr>
<tr>
<td>Under 60 hours</td>
<td>63</td>
<td>37</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>59</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

This negative result may be a function of the inadequacy of hours worked as a measure of workload pressures since number of hours worked in any one week is only a rough indicator of workload pressures in terms of the regularity of working schedules, overnight absence, weekend working and workload experiences over time. So it was decided to investigate the relationship between workload pressures and personal distress by using seniority of husbands' position as an indicator of these pressures. This decision was based on respondents' suggestions that workload pressures, in terms not only of number of hours worked but also of regularity of working hours and overnight absence, decrease with seniority of position. Further, seniority of position may also be regarded as an indicator of both mobility and
income pressures since, with the achievement of senior registrar or university lecturer status, the hospital doctor achieves both a larger income and greater security of office and is therefore less mobile. So we may expect wives of registrars to be under greater pressure than wives of senior registrars or university-employed doctors.

When this relationship is tested, we find that most wives of registrars experience distress, while wives of senior registrars and university-employed doctors are as likely as not to experience distress. (Table 7:9).

<table>
<thead>
<tr>
<th>Husband’s position</th>
<th>Distress</th>
<th>No Distress</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Registrars</td>
<td>71</td>
<td>28</td>
<td>100 21</td>
</tr>
<tr>
<td>Senior Registrars or</td>
<td>53</td>
<td>47</td>
<td>100 17</td>
</tr>
<tr>
<td>Lecturers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>37</td>
<td>100 38</td>
</tr>
</tbody>
</table>

2. Family size

The consequences of work for family life are likely to be related not only to the conditions and circumstances within which the occupational role is performed, but also to conditions of family life. Family size, in particular, seems likely to affect the objective intensity of work-family tensions.
As the family increases in size, we may expect the difficulties involved in running a household and in caring for children to increase. With a first baby, there are difficulties and anxieties arising from inexperience in the art and skills of child-management, and from the sudden transition from the role of working wife to the role of non-working mother. A second baby is, in itself, less of a problem than was the first for the young wife has now learned something of the art and skills of child-management. Nevertheless two babies are more work than one, and the young mother is possibly less mobile than she was when there was only one child. It therefore seems not unlikely that, as the family increases in size, the young wife may have greater need of her husband’s help in household management and child-care and of his companionship. It is also likely that as the children grow older she will come to feel, in a way that she did not when the children were babies, that a part-time father is no good thing.

<table>
<thead>
<tr>
<th>Family size</th>
<th>Distress</th>
<th>No Distress</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>one child</td>
<td>46</td>
<td>54</td>
<td>100</td>
</tr>
<tr>
<td>2 or more children</td>
<td>72</td>
<td>28</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>37</td>
<td>100</td>
</tr>
</tbody>
</table>
The data lends some support to this hypothesis. Though wives with one child are as likely as not to experience distress, most wives with two or more children experience distress (Table 7:10).

When seniority of husband's position is held constant, we find that distress is likely to be greatest where registrar status occurs in conjunction with a family size of two or more children, and least where senior registrar status occurs in conjunction with a family size of one child. (Table 7:11).15

In sum, the data seems to suggest that there is some relationship between experienced 'personal distress' and the intensity of pressures to which wives are exposed as indicated by their husbands' position on the one hand, and family size on the other hand.

<table>
<thead>
<tr>
<th>TABLE 7:11</th>
<th>INTENSITY OF PERSONAL DISTRESS EXPERIENCED BY WIVES OF HOSPITAL DOCTORS BY FAMILY SIZE AND HUSBANDS' SENIORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands' Seniority</td>
<td>Family Size</td>
</tr>
<tr>
<td>Registrars</td>
<td>1 child</td>
</tr>
<tr>
<td></td>
<td>2 or more children</td>
</tr>
<tr>
<td></td>
<td>1 child</td>
</tr>
<tr>
<td>Senior Registrars/ University Lecturers</td>
<td>2 or more children</td>
</tr>
<tr>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
3. Variations in degree of geographical mobility

Geographical mobility is, as has been shown, problematic in that it tends to make for transience in social relationships and for the isolation of the elementary family. The participation by the husband in family life is, it has been suggested, an adaptive response to the isolation occasioned by mobility. It thus seems likely that the problems created by workload pressures will be compounded by geographical mobility since it is mobile wives who are particularly needful of their husbands’ help in child-care and domestic tasks and of their husbands’ companionship. We might therefore expect that distress might be greater among wives who are subjected to geographical mobility than among those who are not.

Table 7:12 suggests that this is in fact so. Further, it would seem that there is some tendency for mobile registrars’ wives to be more distressed than mobile senior registrars’ wives. There are two possible explanations of this. Firstly, as I have already suggested, registrar status seems to be associated with particularly heavy workload pressures. So it may be that registrars’ wives who are exposed to both mobility and workload pressures are particularly likely to be distressed. Secondly, at registrar level the experience of mobility is likely to be both more recent and greater than at senior registrar level. This, of course, suggests that the effects of mobility may be temporary.

4. Marital expectations

Prima facie, reactions to situationally-structured work-family conflicts are likely to be influenced by expectations of marriage as well as by wives’ attitudes to their husbands’ occupational
aspirations and their belief in the importance of self-fulfilment in work. If a young wife thinks that participation in domestic tasks, the acceptance of responsibility for the children and companionship are important aspects of a husband's role, and at the same time believes that the achievement of occupational goals and of self-fulfilment in work is important, then she is on the horns of a dilemma.
For her desire that he should achieve his occupational goals will be in conflict with her expectations of marriage where the commitments necessary to the achievement of occupational goals are not compatible with an active participation in familial life.

In examining the relationship between valuations of the husband role and the incidence of personal distress, those wives for whom objective pressures seem to be relatively low, that is the wives of senior registrars or university lecturers with only one child, were excluded from the sample. This was done since the question of attitudes and expectations of marriage is less pertinent where situationally-structured work-family tension is comparatively slight and, all things being equal, marital expectations may therefore be realised.

When senior registrars and university lecturers with one child are excluded from the sample (leaving a sample of 33) and the relationship between the incidence of personal distress and different definitions of the husband role is explored, the relationships shown in Table 7:13 emerge.

The aspects of family life which appear to be associated with distress are companionship and the sharing of responsibility for children. Wives who rate companionship and the sharing of responsibility for children very highly are more likely to be distressed than wives who do not. These relationships appear to hold within each family size and seniority category (Table 7:14).

The importance of the high valuation of companionship and the sharing of responsibility for children in contributing to stress
TABLE 7:13  INTENSITY OF PERSONAL DISTRESS EXPERIENCED BY WIVES OF JUNIOR HOSPITAL DOCTORS BY VALUATIONS OF THE HUSBAND ROLE

<table>
<thead>
<tr>
<th>Definitions of the husband role</th>
<th>Distress</th>
<th>No Distress</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1. Companionship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1</td>
<td>84</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Scored 2/3/4</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>70</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td><strong>2. Sharing of responsibility for children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1</td>
<td>73</td>
<td>27</td>
<td>100</td>
</tr>
<tr>
<td>Scored 2/3/4</td>
<td>55</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>70</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td><strong>3. Participation in domestic chores</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1/2</td>
<td>75</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Scored 3/4</td>
<td>68</td>
<td>32</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>70</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td><strong>4. Breadwinning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1/2</td>
<td>77</td>
<td>24</td>
<td>101</td>
</tr>
<tr>
<td>Scored 3/4</td>
<td>62</td>
<td>38</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>70</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td><strong>5. Either companionship or sharing of responsibility for children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1</td>
<td>81</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>Neither companionship nor sharing of responsibility for children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scored 1</td>
<td>28</td>
<td>72</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>70</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>
### Table 7.14

**Intensity of Personal Distress Experienced by Wives of Hospital Doctors by Valuation of Husbands' Role and Husbands' Position and Family Size Categories**

<table>
<thead>
<tr>
<th>Husbands' Position and Family Size</th>
<th>Companionship 1</th>
<th>Companionship 2/3/4</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Distress (n = 23)</td>
<td>Distress (n = 15)</td>
<td>(n = 38)</td>
</tr>
<tr>
<td>Registrars with two children</td>
<td>7 -</td>
<td>3 3</td>
<td>13</td>
</tr>
<tr>
<td>Registrars with one child</td>
<td>4 2</td>
<td>1 1</td>
<td>8</td>
</tr>
<tr>
<td>Senior Registrars with two children</td>
<td>5 1</td>
<td>3 3</td>
<td>12</td>
</tr>
<tr>
<td>Senior Registrars with one child</td>
<td>1 3</td>
<td>- 1</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sharing of responsibility for children</th>
<th>Sharing of responsibility for children</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distress (n = 26)</td>
<td>Distress (n = 12)</td>
<td>(n = 38)</td>
</tr>
<tr>
<td>Registrars with two children</td>
<td>7 -</td>
<td>3 3</td>
</tr>
<tr>
<td>Registrars with one child</td>
<td>5 3</td>
<td>- -</td>
</tr>
<tr>
<td>Senior Registrars with two children</td>
<td>5 2</td>
<td>3 2</td>
</tr>
<tr>
<td>Senior Registrars with one child</td>
<td>1 3</td>
<td>- 1</td>
</tr>
</tbody>
</table>

*This group is included here for the sake of completeness*
reactions is highlighted when valuation of these dimensions of the husband role is considered together. Wives who value either companionship or the sharing of responsibility for children highly are far more likely to be 'distressed' than wives who value neither highly. While it would be unwise to attach too much importance to this result in view of the fact there are not very many wives who do not value either of these aspects of the husband role highly, we can say that the evidence points to a relationship between the importance attached to companionship in marriage and the sharing of responsibility for children and distress reactions to structured work-family tensions which it would be fruitful to explore further.

It is hardly surprising that there is no relationship between the importance attached to participation by husbands in domestic tasks and 'distress' since this aspect of the husband role is not much valued.

There also seems to be no relationship between definitions of the breadwinning role and distress - wives who value the breadwinning role highly are as likely as wives who do not to experience distress. This finding is of particular interest because it highlights the conflict that exists between different sets of values: it suggests that, even where wives regard as important not only self-fulfilment in work but also the achievement of income and status rewards and regard such rewards as important to family welfare, they may not be able to tolerate commitments entered into for the sake of advancing income and status goals where these commitments interfere with other dimensions of family life.
5. Medical background of wives

The wives of 58% of hospital doctors in my sample had either worked in a medical environment - as doctors, nurses or physiotherapists - or were the daughters of doctors. It was frequently argued by these women or by their husbands that a medical background provided a first-hand knowledge of the conditions of a doctor's working life. Consequently, wives with a medical background were prepared for and therefore able to tolerate these conditions with equanimity. We may, therefore, hypothesise that wives with a medical background are less likely to experience personal distress than wives with a non-medical background.

My findings are in the expected direction. (Table 7:15). The relationship seems to hold within each family size and seniority category, with the exception of the wives of senior registrars or lecturers with one child, where the numbers are very small.

CONCLUSIONS

In sum, it would seem that nearly two-thirds of the wives of junior hospital doctors are likely to experience the situationally-structured incompatibilities between work and family as distressing. Further, the inability to tolerate with equanimity structured tensions between work and family may be a factor in marital disharmony. This is evidenced by (a) the fact that junior hospital doctors and their wives are more likely to be not very satisfied with marriage than general dental practitioners and their wives, and (b) the relationship found between wives' sympathy with their husbands' 'feelings about work' and the perception of wives as sympathetic by husbands and marital satisfaction.
TABLE 7:15  INTENSITY OF DISTRESS EXPERIENCED BY WIVES OF HOSPITAL DOCTORS BY MEDICAL BACKGROUND

<table>
<thead>
<tr>
<th>Medical background</th>
<th>Distress</th>
<th>No Distress</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Medical background</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Non-medical background</td>
<td>81</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>37</td>
<td>100</td>
</tr>
</tbody>
</table>

1. Wives of registrars with two children:
   - medical background: 50
   - non-medical background: 100

2. Wives of registrars with one child:
   - medical background: 60
   - non-medical background: 67

3. Wives of senior registrars or lecturers with two children:
   - medical background: 50
   - non-medical background: 100

4. Wives of senior registrars or lecturers with one child:
   - medical background: 23
   - non-medical background: 100
In attempting to explain variations in the intensity of the distress experienced by wives when subjected to situationally-structured work-family tensions, it was found that distress reactions are likely to vary directly with the severity of these tensions (as indicated by the conjunction of a junior position with a large family and geographical mobility).

But it seems that we must also take into account wives' attitudes both towards their husbands' occupational aspirations and towards marriage. We must consider not only their situation but also the way in which they define their situation in the light of their values and aspirations. This is suggested by the fact that, where wives value companionship very highly, or where they expect their husbands to share with them responsibility for the upbringing of their children, they tend to be distressed by the encroachment of work on their family lives. In such a situation, their expectations of marriage are incompatible with any attitudes they may hold regarding the legitimacy of the demands of work.

At the same time, it seems that where wives have a medical background, they have some knowledge of the difficulties they are likely to encounter, and are thus better prepared for and better able to tolerate these difficulties.

Finally, the considerable evidence I have presented of work-family tension in hospital medicine calls in question the Parsonian model of a 'fit' between modern occupational systems and the conjugal family. For it seems clear that occupational situations and occupational values may create a state of affairs in which the problems posed by
geographical mobility and the consequent isolation of the family are not resolved by a marital partnership since heavy workloads preclude the active participation of the husband-father in family life. This suggestion is corroborated by the Pahls' work on managers and by Young and Willmott's work on professional and managerial people. Further, as Young and Willmott point out, tension between work and family may also exist for manual workers on shiftwork.

This conflict could be resolved by a lowering of career aspirations, with a concomitant lowering of participation in work life and refusal to accept geographical mobility. There are scattered suggestions in the literature that this happens at the working-class level - that at this level family commitments may be used as an excuse for absenteeism and may lead to lowered participation in trade union activity. Further, both the Pahls and Young and Willmott detect the beginnings of a middle-class reaction against competition in the workplace, a reaction led by young wives who, though believing in the importance of occupational achievement, are unwilling to sacrifice themselves and their family lives for the sake of their husbands' careers. Edgell suggests that failure in the workplace produces meagre satisfactions from, and an instrumental orientation to, work. This, in turn, leads to home-centredness. Following McKinley, Edgell refers to this process as 'role compensation', that is as an attempt to gain status and satisfaction in ascribed roles when the individual is unsuccessful in achieved roles. Edgell cites evidence from Oeser and Hammond in support of his argument.
However, my study suggests that hospital doctors retain their career aspirations and that these aspirations are endorsed by their wives. Given this, they either subordinate the family to the achievement of career goals or attempt to achieve both career goals and a family-centred marital partnership. If they adopt the latter strategy, they are confronted by the considerable problems and stress that the pursuit of incompatible goals necessarily involves. As I have shown, some hospital doctors attempt to resolve this conflict by resorting to collective action aimed at the modification of their occupational situation. Even so, this action seems to be concentrated on achieving greater career security (so as to increase the certainty of achieving consultant status) and on improving their financial situation vis-a-vis general practitioners. The reduction of mobility and of workloads seems to play a relatively minor part in their endeavours.

The lowering of work goals is not, in fact, a ready solution to work-family conflict. For the lowering of career goals may injure the family's living standards and prestige in the community. Indeed, there is a tendency for marriage and family responsibilities to increase commitment to work (in terms of a commitment to high earning power). Moreover, if Scanzoni is right, achievement and success are associated with marital cohesion. Scanzoni argues that the more positively the husband performs his economic duties, the more positively the wife defines her economic rights as being met, and so the more positively she performs her instrumental and expressive duties. The more this is true, the more the husband defines his expressive rights as being met, and the more positively he performs
his expressive duties. Thus the economic rewards the husband-father provides induce motivation in the wife to respond positively to him, and her response in turn gives rise to a continuing cycle of rectitude and gratitude. Conversely, failure in the occupation system adversely affects a man's status in the family, as studies of the matriloclal family among American and West Indian lower class Negroes and of the effects of unemployment on family relationships have shown. Scanzoni suggests that this relationship between success and achievement is a function of the dominant cultural ethos of modern Western Societies. In this ethos achievement and success are symbols of personal worth; the man who fails in the occupational system is not a worthwhile person. The Protestant Ethic is still with us.

This was precisely the argument my husbands and wives advanced to legitimate the allocation of time to work, the acceptance of mobility and the pursuit of consultant status in hospital medicine.

But - and here we come back to the central theme of this study - these occupational values are incompatible with modern family values. A lowering of career goals may injure the family's status in the community and the husband-father's standing within the family. But the retention of career aspirations inhibits the realisation of a family-centred marital partnership. This is the paradox that faces the breadwinner in our society.
CHAPTER VIII

The Marital Partnership

It is, I suggested in my opening chapter, a commonplace of family sociology that 'modern' marriage constitutes 'a partnership'. This partnership is variously seen as involving:
1. mutual emotional support;
2. the sharing of responsibility for child-rearing and household management;
3. companionship in leisure activities and shared friendships;
4. the equality of husband and wife with consensus in decision-making.

The marital partnership is seen by most theorists as existing within the context of the isolation of the elementary family and, given this, as not only facilitating family functioning in the absence of resources once provided by close-knit networks but also as providing a salve for psychic wounds sustained in a competitive and individualistic society and as protecting the individual against anomie. From another viewpoint, it is suggested that couples are living out their lives in a cultural context conducive to partnership in marriage in that democratic ideologies emphasising the equality of women with men, and psychotherapeutic ideologies emphasising the emotional needs of the individual and mutuality of consideration in personal relationships are current. If this is so, then the situational context and the 'ideational' context within which marriage is lived out in modern society are mutually reinforcing of partnership in marriage.

(232)
But this approach to marriage overlooks the occupational role of the husband-father. I have argued that the realisation of occupational goals is incompatible with the realisation of a family-centred marriage partnership. In the preceding chapters, I examined the way in which the occupational situation and values of junior hospital doctors and general dental practitioners affect family life in terms of:

1. financial provision;
2. geographical mobility;
3. workloads and consequent limitation of family activity.

In this concluding chapter, I draw together those of my findings that relate to the marriage relationship itself. In doing so, I seek to delineate the way in which, given a particular constellation of occupation situational exigencies and occupational values, the marital partnership may be based not on the husband-father's involvement in family activity, but on the support the wife provides for his career.

**PARTICIPATION IN FAMILY ACTIVITY BY HUSBANDS**

As I reported in Chapter VI, the workloads of most junior hospital doctors are in excess of 50 hours per week. By comparison the workloads of general dental practitioners exceed 50 hours per week in a few cases only. As a result, participation by junior hospital doctors in familial activity is more limited than that of general dental practitioners.
In general terms, this more limited participation by hospital doctors in family life means that they and their wives have less time together and so cannot have the sense of a shared life that may come from a husband's active participation in family life. However, the full effect of this more limited participation in family life becomes apparent only when participation in different areas of activity is examined. When this is done, we find that the area of family activity most affected by heavy workloads is the area which is perhaps most important for the marital partnership – home leisure.

The extent to which different areas of familial activity are affected by heavy workloads was examined by dividing family activity into four categories:

1. household management;
2. child-rearing;
3. social activity;
4. home leisure.

When this is done, and when the amount of time spent by hospital doctors and dentists in each area of activity is compared, we find that there is little difference between doctors and dentists in the amount of time they spend in household management, child-rearing and social activity. Participation in these activities is, in fact, low in both groups (Table 3:1).

In other words, the workloads of hospital doctors seem to have little effect on these dimensions of the conjugal relationship. And perhaps this was to be expected; in most households the husband is out of the home and at work for the greater part of the day and the
### TABLE 8:1 DIFFERENTIAL PARTICIPATION BY JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS IN DIFFERENT AREAS OF FAMILY ACTIVITY

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Doctors percentage</th>
<th>Dentists percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctors n</td>
<td>Dentists n</td>
</tr>
<tr>
<td><strong>Child-rearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5 hrs</td>
<td>68</td>
<td>63</td>
</tr>
<tr>
<td>6 - 10 hrs</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>11 hrs &amp; over</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Totals %</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5 hrs</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>6 - 10 hrs</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>11 hrs &amp; over</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Totals %</td>
<td>101</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td><strong>Home leisure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5 hrs</td>
<td>24) 65</td>
<td>13) 38</td>
</tr>
<tr>
<td>6 - 10 hrs</td>
<td>41) 25</td>
<td>25</td>
</tr>
<tr>
<td>11 - 15 hrs</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Over 15 hrs</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>
burden of household management and child-care necessarily falls to the wife; social activities are necessarily limited by baby-sitter problems and may be further limited by financial circumstances.

However, there are various household management activities which are not necessarily of a day-time nature, and in which husbands could therefore participate. Tasks such as these - house-purchase, furniture-buying and the buying of presents for the children - are often of a non-routine nature and may not therefore be covered in a week's diary-keeping. Because of this, a husband's participation in non-routine activities was explored by asking wives who usually pays the bills, buys presents for the children, sends off Christmas cards, and takes the lead in house-purchase and furniture-buying. Patterns of participation are shown in Table 8:2.

As this Table shows, bills generally seem to be paid by husbands and Christmas cards sent off by wives in both groups. However, hospital doctors are slightly less likely than dentists to pay bills and to join their wives in sending off Christmas cards. Doctors are also less likely than dentists to take the lead in house-purchase. They do, however, tend to join their wives in looking for a house, so that although dentists may spend more time in house-purchase than doctors, house-purchase is more likely to be a shared affair among doctors and their wives. Differences between hospital doctors and dentists in respect of these three activities are slight, but more considerable differences emerge where buying furniture and presents for the children are concerned: doctors are considerably less likely than dentists to be involved in both these activities.
TABLE 3:2  IN VolVEMENT OF JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS IN MAJOR HOUSEHOLD TASKS

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
</tr>
<tr>
<td><strong>Paying Bills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>74.82</td>
<td>87.93</td>
</tr>
<tr>
<td>Husband and/or Wife</td>
<td>8.30</td>
<td>6.00</td>
</tr>
<tr>
<td>Wife</td>
<td>13</td>
<td>6.00</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>99</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
<tr>
<td><strong>Sending off Christmas Cards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>3.21</td>
<td>-</td>
</tr>
<tr>
<td>Husband and/or Wife</td>
<td>18.30</td>
<td>38.00</td>
</tr>
<tr>
<td>Wife</td>
<td>79.69</td>
<td>63.00</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
<tr>
<td><strong>House Purchase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>19.86</td>
<td>40.80</td>
</tr>
<tr>
<td>Husband and/or Wife</td>
<td>67.28</td>
<td>40.00</td>
</tr>
<tr>
<td>Wife</td>
<td>14.29</td>
<td>20.00</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>36</td>
<td>10</td>
</tr>
<tr>
<td><strong>Furniture Purchase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>13.39</td>
<td>19.63</td>
</tr>
<tr>
<td>Husband and/or Wife</td>
<td>26.58</td>
<td>44.00</td>
</tr>
<tr>
<td>Wife</td>
<td>61.41</td>
<td>38.00</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
<tr>
<td><strong>Presents for Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>10.39</td>
<td>17.75</td>
</tr>
<tr>
<td>Husband and/or Wife</td>
<td>29.92</td>
<td>58.00</td>
</tr>
<tr>
<td>Wife</td>
<td>61.41</td>
<td>25.00</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>12</td>
</tr>
</tbody>
</table>

1. Excludes 6 dentists and 2 doctors where house-purchase took place prior to marriage.

2. Excludes 4 dentists and 7 doctors where the children were considered too young for presents.
The inference I would like to draw from the existence of these differences between hospital doctors and general dental practitioners — namely that they are to be explained by heavy workloads — is supported by the spontaneous comments of some wives. These comments elucidate the way in which work may affect participation in family tasks. For instance, one wife said that she paid the bills because she was doing everything she could to save her husband, who was preparing for an examination, time. That this practice, once begun, may become established routine is demonstrated by the comments of another wife who said that she started paying the bills at a time when her husband was 'sleeping in a lot' and somehow continued to do so.

Comments about house-purchase and furniture-buying suggest that wives may first survey the field (by looking at advertisements, doing the telephoning, going the rounds of the shops) because their husbands have not the time. Husbands and wives then look at houses or furniture, as the case may be, which the wives had decided were worth following up. On the other hand, husbands may sometimes be forced to play the major part in house-buying when this is occasioned by geographical mobility and the whole family cannot move until a house is acquired. In such an event, husbands go house-hunting and wives pay a lightning visit to the new place to look at houses husbands have decided are worth considering.

In sum, the overall pattern of participation in 'major' household management activities suggests that hospital doctors are somewhat less likely than dentists to participate in these activities. These are the kinds of activities which we might expect husbands to be involved in
in a partnership marriage by virtue of the fact that these activities do not necessarily fall within the confines of the standard working week.

But if neither hospital doctors nor dentists spend much time in routine household tasks, child-rearing and social activity, and if doctors are only slightly less likely than dentists to participate in non-routine household management tasks, there is a marked difference between hospital doctors and dentists in the amount of time they spend in home leisure - watching television, listening to music, reading, talking with their wives or indulging in other hobbies. Home leisure may not always be shared leisure, but there is nevertheless some measure of companionship for wives in the use by husbands of the home they share as a place of recreation and relaxation, indeed in the mere presence of the husband in the home. And hospital doctors and their wives are deprived of this kind of companionship.

This difference between hospital doctors and dentists in participation in home leisure is, I suggest, of particular importance for their marriage relationship - for feelings of 'mutuality', of a shared life, of partnership in marriage. As I have suggested, household management and child-care are necessarily largely undertaken by wives, and social activities are limited by the exigencies of child-rearing. Thus, any sense of having a shared life, any feelings of mutuality couples may experience must be derived from evenings spent together in quiet relaxation, talking about their days' activities, soothing each others' anxieties over the things that 'have gone badly' during the day, or sharing their pleasure in the 'things that have gone well'.
If couples do not share their home leisure in this way, then their relationship may be segregated in nearly every way. That this may in fact be so is evidenced by differences I found, firstly, in the extent to which doctors' and dentists' wives talk about family matters and, secondly, in the depth of the emotional bond between husbands and wives.

The extent of communication between husbands and wives about family matters was explored by asking wives: "When your husband comes home in the evening do you tell him about the things you did during the day?" As Table 8:3 shows, doctors' wives are considerably less likely than dentists' wives to talk to their husbands about the events of the day - and this is so despite the fact that doctors are as likely as dentists to profess interest in their wives' day (Table 8:4).

---

**Table 8:3**
**Extent to which wives of junior hospital doctors and general dental practitioners talk to their husbands about the day's events**

<table>
<thead>
<tr>
<th>Amount of Communication</th>
<th>Doctors' Wives</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
</tr>
<tr>
<td>Talks about everything/ most things</td>
<td>47</td>
<td>75</td>
</tr>
<tr>
<td>some things</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>few things/nothing</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>unclassifiable response</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
<tr>
<td>Interested in</td>
<td>Doctors</td>
<td>Dentists</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>percentage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>everything/most things</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>some things</td>
<td>32</td>
<td>44</td>
</tr>
<tr>
<td>few things/nothing</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>unclassifiable response</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
</tbody>
</table>

Similarly, doctors' wives seem less likely than dentists' wives to use their marital partner as a source of emotional support (Table 8:5).

<table>
<thead>
<tr>
<th>Emotionality Index</th>
<th>Doctors</th>
<th>Dentists</th>
<th>Doctors' Wives</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scores of 5 and less</td>
<td>31</td>
<td>19</td>
<td>8)56</td>
<td>-</td>
</tr>
<tr>
<td>Scores of 6 - 8</td>
<td>50</td>
<td>63</td>
<td>48)</td>
<td>38</td>
</tr>
<tr>
<td>Scores of 9 and over</td>
<td>19</td>
<td>19</td>
<td>45</td>
<td>63</td>
</tr>
<tr>
<td>Totals %</td>
<td>100</td>
<td>101</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
<td>38</td>
<td>16</td>
</tr>
</tbody>
</table>
This is also true of doctors vis-à-vis dentists though the difference here is slight. This finding is based on an emotionality index which was obtained by scoring responses (as indicated) to the following questions:

Would you say that you are sympathetic to how your husband/wife thinks and feels about things? (response categories: everything - scored 3; most things - scored 2; some things - scored 1; a few things, nothing - scored 0)

Would you say that your wife/husband is sympathetic to how you feel and think about things? (response categories: everything - scored 3; most things - scored 2; some things - scored 1; a few things, nothing - scored 0)

How much of your innermost hopes and feelings do you tell your wife/husband? (response categories: all - scored 3; most - scored 2; some - scored 1; a few/none - scored 0)

When you are bored, worried or depressed, what do you do about it? (spontaneous naming of spouse as a therapy agent: scored 1)⁴

Would you say that your wife/husband contributes to your self-confidence? (response categories: to a very great extent - scored 3; to a great extent - scored 2; to some extent - scored 1; a little/not at all - scored 0)

Scores for each item were summed, giving an emotionality index ranging between 0 - 13.

While it cannot be said with certainty that the depth of the emotional relationship between husbands and wives is impaired by a lowering of participation in home leisure (and possibly by the attitudes to marriage and work that may accompany this lowered participation), the evidence is at least suggestive. On the other hand, it must also be noted that nearly half of the doctors' wives continue to derive emotional succour from their marriage relationship, and that husbands are always substantially less likely than wives to turn to their spouse for succour.
CAREER-SUPPORT AS AN ELEMENT OF THE MARITAL PARTNERSHIP

But if heavy workloads undermine an important element in the marital partnership, the sharing of home leisure (thereby reducing communication about family matters and weakening the emotional bond between husband and wife), another element is added: wifely involvement in the occupational role of husbands through the support that is provided for career goals. This support lies in the organisation of family life around the exigencies of work.

Wifely support for career goals is not usually advanced in the literature as a possible dimension of the marital partnership. But the arguments which hospital doctors and their wives frequently advanced, when discussing their aims in life or the consequences of work for family life, suggest that wifely support for career goals may be an important element in a marital partnership.

Work, hospital doctors and their wives argue, is central to a man's life and happiness and thus to marital happiness. Therefore, wives ought to share their husbands' occupational aspirations and support their career goals. Consequently, if job situations and/or the achievement of occupational goals necessitate evening and weekend work, wives must cooperate in enabling their husbands to spend their evenings and weekends working. The good hospital doctor's wife, they believe, is one who supports their husbands' career goals by assuming the major responsibility for running the household and bringing up the children, and who accepts, uncomplainingly, a limited social life and loneliness.5
Support for career goals is considered to be important not only in terms of acceptance of high workloads and its consequences for family life, but also in terms of the acceptance of high rates of geographical mobility. As I showed in chapter V, mobility among hospital doctors and their wives is much higher than among dentists and their wives. This mobility places doctors' wives in a situation in which their social relationships outside the elementary family may be tenuous. They are thus deprived of assistance with child-care and household management and of companionship from sources external to the family in a situation in which they are also denied their husbands' assistance by virtue of his heavy workloads. However, as the discussion of the consequences of mobility for family life showed, most hospital doctors and their wives believe that wives should, in the interests of their husbands' careers, accept mobility, organize the moving of the household and tolerate the problems involved.

Moreover, acceptance of heavy workloads and geographical mobility, and of the consequent family problems, is defined as part of a wife's role by both hospital doctors and their wives even though the fruits of the occupational system—in terms of a high and secure income and a comfortable life style—are denied them during the family-building stage of the life cycle.

As I have shown, job insecurity, low income levels, lengthy apprenticeship and intense competitiveness are inherent in the occupational situation of junior hospital doctors. However, both hospital doctors and hospital doctors' wives define a good wife as one who accepts a low income gracefully, contrives to run the home
on it efficiently, and is not envious of friends and relatives with a higher standard of living.

In sum, comments made by hospital doctors and hospital doctors' wives, when discussing the implications of work for family life, suggest that they define a hospital doctor's wife's role as involving support for occupational goals through the organisation of family life around the exigencies of work. 7

This evidence (derived from comments made during discussions of the consequences of work for family life) of the importance to junior hospital doctors and their wives of wifely support for career goals as an element in the marital relationship is confirmed by responses to the question: "In what, if any, ways do you think the wife of a hospital doctor/dentist could be most helpful to her husband in his career?" Responses to this question fall into the following categories:
1. supportive - giving sympathy and encouragement;
2. acceptance of the pressures of work (workloads, geographical mobility and low income rewards);
3. home-management - running the home smoothly;
4. social - entertaining and presenting a good image to colleagues, chiefs and (in the case of dentists) patients;
5. collaborative - rendering secretarial or book-keeping assistance.

Table 8:6 shows that nearly three-quarters of the hospital doctors and nearly one-half of their wives think that a hospital doctor's wife can help her husband in his career by accepting the pressures of work.
By contrast dentists and their wives do not attach importance to acceptance of work pressures as part of a wife’s role. On the other hand they, far more frequently than doctors and their wives, believe that wives can help their husbands in their careers by giving emotional support. The greater importance dentists and their wives attach to this form of career assistance may be related to the dentists’ experience of work as an expenditure of effort without intrinsic satisfactions.⁸

As Table 8:7 indicates, both hospital doctors and dentists tend to perceive their wives as actually providing them with the kind of career-help they expect.⁹ Wives, perhaps self-deprecatingly, are less likely to see themselves as being as helpful as they could be.
TABLE 3:7 PERCEPTION OF WIVES AS HELPFUL TO THEIR HUSBANDS’ CAREERS

<table>
<thead>
<tr>
<th>Wives perceived as:</th>
<th>Hospital Doctors’ Dentists’ Practitioners Wives Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
</tr>
<tr>
<td>Helpful</td>
<td>63)79 56 29)53 37)50</td>
</tr>
<tr>
<td>Helpful with qualifications</td>
<td>16) 0 24) 13)</td>
</tr>
<tr>
<td>Not helpful</td>
<td>16 13 32 37</td>
</tr>
<tr>
<td>Having no role to play/response unclassifiable</td>
<td>5 31 16 13</td>
</tr>
<tr>
<td>Totals %</td>
<td>100 100 101 100</td>
</tr>
<tr>
<td>n</td>
<td>38 16 38 16</td>
</tr>
</tbody>
</table>

Thus, both doctors and their wives, and general dental practitioners and their wives believe that wives have a role to play in relation to their husbands’ careers, but their definition of that role differs.

Further, the role the hospital doctor’s wife is expected to play in relation to her husband’s career is probably more exacting and more important to occupational success than the role the general dental practitioner’s wife is expected to play. The doctor’s wife is called upon to organise her household around the exigencies of his working life, while the dentist’s wife is required only to listen sympathetically to her husband’s discontents. The latter role may be difficult but is perhaps not generally as demanding as the former. In this context, hospital doctors sometimes stated,
as dentists never did, that a career in hospital medicine is made possible only by virtue of wifely support: it is because of wifely support that family life does not intrude on work commitments; without that support the situation becomes intolerable and the doctor quits. Again, only 25% of dentists (compared with 39% of hospital doctors) mentioned more than one way in which wives could help their husbands in their careers; and nearly one-third of the dentists (compared with only 3% of the doctors) saw no way in which wives could be helpful.

In sum, in hospital medicine wives have a clearly defined and important role to play in supporting their husbands in the pursuit of their career goals, while in general practice wives are assigned a more limited, less important role. There thus exists a marital partnership in hospital medicine, but this partnership revolves around the joint endeavours of husband and wife to ensure the achievement of occupational aspirations. Such a partnership differs from the partnership commonly portrayed in the literature in that the familial involvement of husbands is limited, while wives provide support for the achievement of career aspirations. It is a work-centred rather than a family-centred partnership.

By contrast, the wives of general dental practitioners are assigned a more limited, less important role vis-à-vis their husbands occupational role, and dentists are more likely to be involved in familial activity (and particularly in the sharing of home leisure with their wives).
These differences in the marital partnership of hospital doctors and general dental practitioners and their wives are, I have argued, related to differences in their occupational situation and occupational aspirations. The limited involvement of hospital doctors in familial activity, and the consequent role of their wives as career-supporters, stems not only from career contingencies that bring heavy workloads, geographical mobility and low earning power during the family-building stage of the life cycle but also from their orientation to work as a 'central life interest'. Given this orientation to work, career paths likely to bring work-satisfaction are embarked upon regardless of career contingencies, and mates are chosen with a view to their suitability for the role they are expected to assume. Doctors' wives, for their part, bring to marriage an orientation in which the achievement of career goals is seen as essential to marital happiness.

By contrast, the career contingencies of general dental practice do not expose dentists to heavy workloads, and are accompanied by geographical stability and high earning power during the family-building stage of the life-cycle. Consequently dentists are free to be involved in family activity, and their wives are not called upon to support career goals by assuming single-handed management of the household and of child-rearing and by accepting loneliness. They are, however, by virtue of the experience of work as intrinsically unrewarding, called upon to provide a smiling refuge after the tensions of the day.
Negative nature of the wife’s role as career-supporter

Doctors’ wives, I have suggested, are expected to play a demanding and important role vis-a-vis their husbands’ careers. Yet the role they are assigned, though important, is a negative role. It is negative in the sense that their actual involvement in their husbands’ work lives is very limited. They do not, and cannot, join their husbands in the care of patients, in teaching or in research work. Their contact with the workplace is minimal. A social role as hostess to colleagues and chiefs is not expected of them.

The negative nature of their role becomes very evident when we examine the amount of communication which takes place between husband and wife about work.

The extent of communication about work between husbands and wives was investigated by asking the following questions:

1. When you come home in the evenings do you tell your wife about things that happened at work? (response categories: everything, most things, some things, few things, nothing)
2. When you have problems at work, do you talk them over with your wife? (response categories: all, most, some, few, none)
3. If you are thinking about changing your job, do you ask your wife’s advice? (response categories: yes, no)

An overall index of the amount of communication taking place was obtained by giving numerical measures to response categories as follows:

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Everything, most, responses</th>
<th>Scored 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Some responses</td>
<td>Scored 1</td>
</tr>
<tr>
<td></td>
<td>Few responses</td>
<td>Scored 0</td>
</tr>
</tbody>
</table>

Question 2:

<table>
<thead>
<tr>
<th>Question 2</th>
<th>All, most, responses</th>
<th>Scored 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Some responses</td>
<td>Scored 1</td>
</tr>
<tr>
<td></td>
<td>Few responses</td>
<td>Scored 0</td>
</tr>
</tbody>
</table>
Question 3: yes responses: scored 1
no responses: scored 0

This produced a communication index ranging between 0 and 5.

<table>
<thead>
<tr>
<th>Index of discussion</th>
<th>Doctors</th>
<th>Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>percentage</td>
<td></td>
</tr>
<tr>
<td>0/1</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>2/3</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>4/5</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Totals: %</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 8:3 shows, firstly, that the amount of communication taking place (as measured by this index) is fairly limited, and, secondly, that there is little difference between doctors and dentists in the extent to which they talk about work.  

Further, comments made in elaboration of responses to these questions suggest that doctors and dentists, when they do talk about work, do not talk about work itself but about the personal relationships of work. They do not discuss the daily routine of work because they consider a blow-by-blow account of the day's events boring. They rarely talk about the clinical aspects of work and their clinical problems because, they say, this side of their working lives is incomprehensible, and therefore uninteresting, to laymen.
So when they do talk about work and work problems, doctors and dentists tend to talk about those things that make one day different from another – disasters, successes, amusing incidents, unusual incidents. They talk about the people they work with and problems concerning personal difficulties with seniors, colleagues, or nursing staff. Plans for the future and problems concerning career strategies are also talked about, but, it would seem, to a lesser extent.

Where discussion of contemplated job changes is concerned, there seems to be a fairly general feeling that career decisions must ultimately be the man's decision.¹³ Men must be free to determine what they want to achieve and how this is to be achieved. Further, these men do believe that wives do not have the knowledge of the work situation necessary for advice-giving. However, elaborated responses suggest that even where career advice is not actually sought, some discussion of contemplated job changes may take place. Sometimes discussion does not go beyond informing the wife of what is happening. But in other cases, particularly where a job-change involves geographical mobility or a major change in career paths (as in a switch from general practice to hospital medicine), wives are consulted and their point of view given consideration.

In sum, communication about work seems to be fairly limited. Any communication that takes place centres not on work itself but on the personal relationships of work and on out-of-the-ordinary events.

Now, it seems to me that where a marriage relationship is work-centred the involvement of wives in the role of their husbands through
communication about work is essential if their role as supporters of their husbands' career aspirations is to take on flesh and blood, and if the tendencies to segregation that may be consequent on their husbands' lowered participation in family life are to be avoided. Discussion would help to make wives knowledgeable about their husbands' working lives, and would give them a sense of sharing in an important part of their husbands' lives. It would also give husbands a sense of sharing an important part of their lives with their wives.

My suggestions as to the importance of communication about work for wives is confirmed by the depth of the interest wives displayed in their husbands' working lives. Most wives profess a considerable interest in their husband's day at work (Table 3:9) and some wives complain of their husbands' uncommunicativeness. Further, volunteered comments suggest that wives regard interest in the job as important to their marriage relationship. They see talk about work as involving them in their husbands' life away from the home by informing them about that life and as therapeutic for husbands. Work, it was said, is so much a part of their husbands' lives and personality that if no interest were taken in it, there would be no relationship.

IN CONCLUSION

In sum, the marital relationship of hospital doctors seems not to approach the partnership which the literature suggests is characteristic of modern marriage in that their participation in family life is, generally, limited. Nevertheless, their marriage may be said to constitute a partnership - a partnership that is
TABLE 3.9 INTEREST FELT BY WIVES OF JUNIOR HOSPITAL DOCTORS AND GENERAL DENTAL PRACTITIONERS IN THEIR HUSBANDS' WORK LIFE

<table>
<thead>
<tr>
<th>Interested in</th>
<th>Doctors' Wives</th>
<th>Dentists' Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>percentage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everything/most things</td>
<td>61</td>
<td>75</td>
</tr>
<tr>
<td>some things</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>few things</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Totals %</td>
<td>101</td>
<td>100</td>
</tr>
<tr>
<td>n</td>
<td>38</td>
<td>16</td>
</tr>
</tbody>
</table>

work-centred rather than family-centred, that is based on the support wives provide for the achievement of career aspirations rather than on the husband-father's involvement in family life. However, wives can only be indirectly involved in their husbands' work lives, and the support that is expected of them is not buttressed by free and full discussion about work.

These findings raise questions as to the extent to which this kind of marital partnership fulfills the functions commonly ascribed to marriage in our differentiated and individualistic society.

It is, as I showed in my opening chapter, a commonplace of structural-functional theory that the conjugal family 'fits' the occupational system in that it (a) allows the geographical and social mobility that facilitates the filling of occupational roles and (b), by its emphasis on emotionality, provides a salve for the
wounds received in a competitive, individualistic and impersonal occupational world. The marriage partnership of hospital doctors and their wives is clearly supportive of the occupational system. Mobility is endorsed, husbands are freed from familial involvement so that they may devote their time to work, emotional support is provided and career goals are legitimated.

Secondly, it is a commonplace of structural-functional theory that, given the isolation of the elementary family, the marital partnership facilitates family functioning through the support husbands and wives give each other in terms of the sharing of household management and child-rearing, of leisure and friendship, and of emotional concerns. But clearly the marital pattern found in hospital medicine is not functioning in this way and, although husband-absence is accepted, wives are beset by problems.

It is important, in this context, to recall that family life is not in fact devalued by hospital doctors and their wives. They do not, it is true, set any particular value on participation by husbands in household tasks; in this respect familial values mesh with occupational values. But the wives of hospital doctors and, to a lesser extent, their husbands value the giving and receiving of emotional support in marriage, companionship and the sharing of responsibility for children. These values clearly cannot be realised if occupational values are pursued. Given this clash of values, work-generated problems may, as I have shown, be experienced as distressing and this may lead to marital tension.
Thirdly, it is very generally suggested that in a society in which Gesselschaftliche relationships are dominant, primary relationships are usually (and often only) experienced in marriage and family life. Marriage thus protects the individual from anomie. From this point of view, marriage may be more important for wives than for husbands. Husbands are caught up in the social relationships of work and may find expressive satisfactions in colleague relationships. Wives, on the other hand, live out their lives in loose-knit social networks and are tied to the home and the domestic round by the exigencies of child-rearing. Their social world may thus effectively consist of their husbands and young children. Therefore, a marriage in which participation by the husband in familial activity (and particularly in home leisure) is limited, and in which the wife's role as supporter of her husband's career aspirations does not involve active participation in his work life and is not sustained by extensive communication about work, leaves wives with very little protection against anomie.

Berger and Kellner, taking up the conception of marriage as functioning to protect the individual from anomie but writing from a phenomenological perspective, suggest that marriage, as a nomos-building instrumentality, represents 'a social arrangement that creates for the individual the sort of order in which he can experience his life as making sense', and as such occupies a privileged status among the significant validating relationships for adults in our society. If this is so, and if my foregoing remarks are valid, then it is for wives rather than for husbands that marriage is particularly important as validating reality. For husbands, experiences in the work sphere (involving encapsulation within a firmly structured career
situation, an ordered daily routine and interaction with colleagues and work associates) may provide the sort of order in which they can experience life as making sense. But non-working wives have no certain set of experiences outside marriage and family life through which their sense of identity may be confirmed. Thus, if husbands are absent, they may be denied the only significant validating relationship available to them in an impersonal society.

Berger and Kellner suggest that the 'nomic instrumentality of marriage is concretised over and over again, from bed to breakfast table, as the partners carry on the endless conversation that feeds on nearly all they individually or jointly experience. Indeed, it may happen eventually that no experience is fully real unless and until it has been thus talked through. The comments of some of my wives suggest both that this on-going conversation is not taking place and that this on-going conversation is necessary to the maintenance of a sense of identity. This is illustrated by comments such as 'our marriage is in my husband's pending tray', 'you become part of the furniture, you know', and by repeated accounts of waiting for a husband's return in the evening as a means of 'diluting the situation', of hungering for conversation about the world of work as a means of achieving vicarious contact with the world at large.

A case study

This study of the marriages of hospital doctors and their wives, and of general dental practitioners and their wives, was a case study of the way in which the marital partnership may be shaped by a particular set of occupational circumstances and values. It has thus
focussed on the much neglected husband-father role. It has shown that in hospital medicine the marital partnership revolves around the achievement of occupational goals, while the family-centred partnership of general dental practitioners and their wives more nearly approaches that commonly portrayed in the literature. It has also revealed fundamental conflicts between work and family life and thereby called in question structural-functional conceptions of a 'fit' between modern occupational systems and the nuclear family system based on the conjugal partnership.

My study was an exploratory study. I was concerned with particular occupational groups who were at a particular point in the life-cycle and who were resident in Edinburgh. However, my findings should be generalisable to other groups of hospital doctors and dentists and to other occupational groups with similar career structures and values. Further work, using larger samples, is now required to test the relationships which my case study suggests exist between occupational role patterns and marital patterns, and to test the explanations I advanced for the experiencing of work-generated family problems as distressing on the personality level. Studies of work-family interaction in other occupational groups and at other points of the life-cycle are required. I have focussed on the impact of work and family life, and have thus provided only tangential evidence of the effect of family values and situational exigencies on the work role. This evidence is, however, sufficient to suggest the possible fruitfulness of further work in this area.
Chapter I: The Problem Explored.

1. E.W. Burgess et al: The Family, 1963 (chap. 1); K. Davis: Human Society, 1948 (p. 24); R. Fletcher: The Family and Marriage, 1962 (pp. 130-133); W.J. Goode: The Theoretical Importance of Love in American Sociological Review, vol. 24, 1959; C. Kirkpatrick: The Family: as Process and Institution, 1963 (pp. 408-411); R. Linton: The Natural History of the Family in R. Anshen (ed.), The Family: Its Function and Destiny, 1949; T. Parsons: The Social Structure of the Family in R. Anshen (ed.), The Family: Its Function and Destiny, 1949; J.R. Udry: The Social Context of Marriage, 1971. Udry contends that 'the importance and generality in American culture of the value of marrying for love is not disputed by any scholar known to this writer, nor would more than a small fraction of Americans reject the idea... Other reasons (for marriage) such as economic gain, achievement, rebellion against parents, escape from loneliness, 'everyone else doing it', and sexual gratification are either culturally unsupported or actually shameful.' (p. 158)

2. W.M. Kephart: The Family, Society and the Individual, 1961 (p. 43). Reminiscent of this statement is Gorer's finding that in 1969 men and women emphasise psychological qualities (love, understanding, affection) as the most important qualities a husband/wife should have, whereas in 1950 they stressed the importance of moral and economic qualities (G. Gorer: Sex and Marriage in England Today, 1971, pp. 72-73).


Notes to Chapter I.

8. E. Bott: op. cit.
   R.G. Blood & D.M. Wolfe: op. cit. (chap. 6);
   J.W. Burgess et al: op. cit. (chap. 1);
   E. Dahlstrom & R. Liljestrom: op. cit.;
   H. Gevron: The Captive Wife, 1966 (chap. 11);
   G. Gorer: Sex and Marriage in England Today, 1971 (chap. 3);
   E.R. Mowrer: The Differentiation of Husband and Wife Roles in

9. E.W. Burgess et al: op. cit. (chap. 1);
   R.G. Blood & D.M. Wolfe: op. cit. (chap. 2);
   R. Fletcher: op. cit. (p. 130);
   E. Mowrer: op. cit.;
   F. Zweig: op. cit. (pp. 27-32).

10. I use the term 'role expectations' to refer to the expectations
    that are held of an actor in a given social position, and the
    term 'role performance' to refer to actual behaviour in a given
    social position. I use the term 'role', idiosyncratically, as a
    convenient shorthand for 'role expectations and role performance'.
    In doing so I do not intend to imply that role behaviour in a
    given social position necessarily accords with the expectations
    that may be held of that position.

11. A term coined by R. Dubin (Industrial Workers' Worlds: a Study
    of the "Central Life Interests" of Industrial Workers in Social
    Problems, vol. 3, 1956) to refer to the area of life on which
    an individual centres his interests and activities and for which
    he has an expressed preference.

    The Family: its Function and Destiny, 1949, and T. Parsons and
    (chap. 1).

13. The isolation of the nuclear family has been questioned. The
    main conclusion to be drawn from extensive work in this area is
    that kin tend to be dispersed and face-to-face interaction is
    thereby impaired, but that some links with kin (particularly with
    parents) are maintained. See, for example, M. Susman: The
    Help Pattern in the Middle Class Family in American Sociological
    Review, vol. 18, 1953;
    E. Litwak: Geographic Mobility and Extended Family Cohesion and
    Occupational Mobility and Extended Family Cohesion both in American
    Sociology Review, vol. 25, 1960;
    C. Bell: Middle Class Families, 1968;

Notes to Chapter 1.

Blood and Wolfe make explicit the implication contained in the work of Parsons and the other authorities cited here to the effect that the place of kin will not be taken by neighbours, workmates or friends. Blood and Wolfe suggest that those forces making for a weakening of kinship relationships—structural differentiation and occupational and social mobility—also weaken social relationships in general. This thesis may, of course, be traced back to Durkheim and Toennis.

Goode, in taking up this thesis, adds a third dimension to the Parsonian model of a 'fit' between modern occupational systems and family systems. He suggests that the competitiveness, individualism and insecurity of an occupational system based on achievement and universalism is 'psychologically burdensome'. The conjugal family 'integrates' with such a system by its emphasis on emotionality; it restores the 'input-output balance of individualism in such a job structure' (p.13).


21. For comments on specific attempts to test the Bott hypothesis see note 48.

22. It could, however, be argued that in industrial societies conditions tending to loose-knit networks are more frequently found than those conditions which tend to close-knit social networks; and further that the mere presence of such conditions differentiate industrial from pre-industrial society. Needless to say a great deal of research into historical and contemporary materials would be needed to validate this characterisation of industrial societies.

23. See note 16.

24. I use the term elementary family to refer to the basic family unit of husband, wife and children without reference to the nature of the relationships within it or the nature of it's relationships with kin. I use the term conjugal family to refer to a family system in which there are 'close' bonds between husband and wife (however these may be defined).


27. ibid. p.23.
Notes to Chapter 1.

23. M. Young & P. Willmott: The Symmetrical Family, 1973 (pp. 84-6).

29. Ibid p. 85.


31. F. Halmos: The Personal Service Society, 1966 (pp. 5-6).


34. M. Young and P. Willmott: Family and Kinship in East London, 1957 (chap. 3). See also:
   M. Komarovsky: Blue-Collar Marriage, 1962 (pp. 76-81).
   Bronfenbrenner (Socialisation and Social Class Through Time and Space in E. MacCoby, T.M. Newcomb and E.L. Hartley, eds: Readings in Social Psychology, 1958) shows that shifts in the pattern of child-care show a striking correspondence to changes in practices advocated in successive editions of U.S. Children's Bureau Bulletins and similar sources of 'expert' opinion.


37. The pervasiveness of psychotherapeutic ideology is, North points out, evidenced by the fact that the category of persons believed to require counselling has been extended from those stigmatised by some official judgment as maladjusted to include ordinary people (The Secular Priests, 1972, p. 251).
   Halmos (The Personal Service Society, 1966) argues that the ideology is propagated not only by professional 'counsellors' (psychiatrists, psychotherapists and social caseworkers) but also by the 'personal service professions' (doctors, nurses, teachers, social workers of all kinds and the clergy) who have been influenced by the 'faith of the counsellors'.

Notes to Chapter 1.

39. The failure to consider the possible inter-relationships between occupational and familial roles may be attributed to two factors. Firstly, academic specialisation has led specialists in family sociology and in industrial sociology to treat each of these areas as relatively closed sub-systems (J. M. & R. E. Pahl: Managers and Their Wives, 1971, pp. 3-4). Secondly, little systematic attention has been given to the husband role.

40. Conversely, of course, family situations and values may affect the occupational role. The relationship is a reciprocal one. As I am concerned with the conjugal relationship, I restrict myself to the analysis of the ways in which the husband-father's occupational role may shape his familial role.

41. Given the variety of contexts (situational and cultural) within which the occupational role is performed, the implications of the occupational role for familial roles are likely to be complex and varying. I here single out for attention the likely implications of upper middle-class occupations as these - given the supposed definition of familial roles - seem likely to be particularly problematic.

42. This has been shown to be the case at the working-class level where family responsibilities tend to lead to shiftworking. See, for example, M. Young and P. Willmott: The Symmetrical Family, 1973 (p. 182) and F. Zweig: The Worker in an Affluent Society, 1961 (p. 55). Further, low earning power has been shown to be associated with marital tension and to affect the husband's status in marriage. See M. Komarovski: Blue-Collar Marriage, 1962 (chap. 13).

43. British empirical work on marriage, and in particular on middle-class marriage, is slight. American studies abound, but their findings are not necessarily applicable to British society. Consequently, my review of the empirical data concentrates on British data.


46. L.A. Shaw, op. cit.

47. M. Young & P. Willmott: op. cit. (chap. 3).

48. There is in fact no firm evidence of a relationship between network connectedness and conjugal role segregation. Supporting evidence is produced by, for example, Turner (Conjugal Roles and Social Networks in Human Relations, vol. 20, 1967), but negative
Notes to Chapter 1.

48. cont. evidence by, for example, Harrell-Bond (Conjugal Role Behaviour in Human Relations, vol. 22, 1969). Contradictory findings may in part be due to the variety of methods used and the difficulty of operationalising either network connectedness or conjugal role segregation. But perhaps, as Toomey (Conjugal Roles and Social Networks in Human Relations, vol. 24, 1971) concludes, after a succinct résumé of previous work in this field and in the light of his own findings, the critical factor may not be network connectedness as such but opportunities for socially gratifying and supportive contacts with others. Moreover, as Turner argued (and as I am arguing), variables other than network connectedness must be taken into account.


51. P. Willmott and M. Young: op. cit. (p. 27).

52. H. Gavron: op. cit. (chap. 12).


56. It may be that the upper middle classes in fact expect 'jointness' in their conjugal relationships, but may not be able to realise these expectations because of the demands of the occupational role. But since little is said of expectations we do not know this. We know nothing of the possible disjunction between expectations and the reality of their spouses' behaviour, or of the tension which might be created by this disjunction.
Notes to Chapter 1.

57. Gavron & Willmott & Young, as well as Blood and Wolfe, do in fact suggest that the apparently lower participation of middle class husbands in family life may be explained by the husband's involvement in work. But this was an ex post facto explanation, advanced en passant, and the full implications and possibilities of tension were not therefore explored. Very recently (and some time after I embarked on this study), the Pahls (Managers and Their Wives, 1971) and Young and Willmott (The Symmetrical Family, 1973) published findings which suggest that husband-father involvement in family life is curtailed as a result of time and 'ego-involvement' in work. Both the Pahls and Young and Willmott suggest that in this situation the dominance of work is increasingly being questioned, particularly by wives, in the light of the marital partnership ideology. Young and Willmott go so far as to suggest (chap. 10) ways in which the occupational system may be modified to permit both husbands and wives to have 'two demanding jobs'. My study is concerned with professionals, not managers. I find that among professionals and their wives the pursuit of occupational aspirations is legitimised and the marital partnership is centred on the joint endeavours of husband and wife to ensure the achievement of occupational aspirations rather than on the joint involvement of husband and wife in family activity. But my findings suggest that despite the legitimisation of occupational aspirations there are tensions.

58. Max Weber's classic discussion of bureaucratisation as the distinguishing feature of modern Western societies remains the starting point for all discussions of large scale organisations (M. Weber; The Theory of Social and Economic Organisation, translated by A.M. Henderson and T. Parsons, 1947). On the distinction that must be made between organisational and independent occupational situations see C. Bell; Middle Class Families, 1969.

59. E. Chinoys; Automobile Workers and the American Dream, 1955; R. Dahrendorf; Class and Class Conflict in Industrial Society, 1959.

60. M. Weber; op. cit.

61. The competitiveness of industrial and commercial work has frequently been described. See, for example, C. Sofer: Men in Mid-Career, 1970 and M. Young and P. Willmott: The Symmetrical Family, 1973 (pp.155-159).


63. ibid.
Notes to Chapter 1.

64. E. Chinoy: op. cit.

65. As evidenced by the fact that a working week of 40 hours is defined as 'normal' in collective agreements. For office staff the standard working week seems to vary between 35-40 hours. Norms regarding the appropriate length of the working day are epitomised in such catch phrases as '9.00-5.00' and 'unsocial hours'.


70. R. Stewart: Managers and their Jobs, 1967. (p.29).

71. A.J. Merrett: How well off are Directors? in E. Forster and G. Bull (eds), The Director, his Money and his Job, 1970 (p.4).


73. M. Young and P. Willmott: op. cit. (p.248).

74. Also of interest is an American study which shows the working week of professors (lecturers) to be 56-60 hours, of aden 45 hours and of dentists 40 hours (J.E.Gerstl: Leisure, Taste and Occupational Milieu in Social Problems, vol. 9. 1961.) All the findings cited here must be interpreted with caution since working hours are variously computed.

75. Watson defines spiralism as 'the progressive ascent through a series of higher positions in one or more hierarchical structures with a concomitant residential mobility through a number of communities'. W. Watson: Social Mobility and Social Class in Industrial Communities in M. Gluckman and E. Devons (eds), Closed Systems and Open Minds 1964 (p.147).

76. C. Ball: Middle Class Families, London, 1969 (chap.2).


78. W.H. Whyte: The Organisation Man, 1956 (part 7).

Notes to Chapter 1.


32. The ample documentary evidence of social class differentials in mobility is aptly summarised by Bell. (C.Bell: Middle Class Families, 1969, chap. 2.)


34. C. Bell: op. cit. (chap 2).
W.H. Whyte, op. cit.

35. C.Bell. op. cit. (chap 2).
M. Stacey: op. cit.

H. Wilensky: op. cit.

37. This is a broad generalisation. Work relationships in many traditional industries extend beyond the workplace door. See, for example, W.Dennis, F. Henriques and C. Slaughter: Coal is Our Life, 1956.


The professional's commitment to work as a central life interest has also been commented on by, among others: A. Etzioni: A Comparative Analysis of Complex Organisations, 1961 (p.10-11).

Cont.
Notes to Chapter 1.

91 cont. L. Orzack: op. cit.;

92. This is suggested by, among others:
T. Caplow: The Sociology of Work, 1954 (p.131);


94. In contrast workers on the shop floor tend to define work in instrumental terms. Work is experienced as unsatisfying by virtue of its repetitiveness, the fragmentation of tasks, and minimisation of skills. It is thus experienced as an expenditure of effort, offering no reward in itself; devotion to the task and identification with workmates and with the work role tend to be minimal. See, for example, R. Blauner: Alienation and Freedom: the Factory Worker and His Industry, 1964;
E. Chinoy: Automobile Workers and the American Dream, 1955;

C. Wright Mills (White Collar, 1951) argues that office workers as well as manual workers are subject to the alienating conditions of work. However, we must beware of assuming that all manual workers are predominantly instrumentally oriented to work. Lockwood (op. cit.) suggests that in traditional industries such as mining, docking and shipbuilding, workers have a high degree of job involvement and find work intrinsically rewarding; Blauner (op. cit.) finds that in the printing industry, which is still based on craft techniques and in which the worker has substantial control over the work process, work is rewarding.

95. E. Greenwood: op. cit. (p.17).
Thus on occasion jobs offering work satisfaction may be preferred to a higher salary. This is true, for example, of the teacher who, preferring teaching to administration, determines to remain a teacher rather than become a headmaster.
Notes to Chapter 1.

96. R. Dubin: op. cit.
   D. Lockwood: op. cit.

97. E. Greenwood: op. cit. (p.17).
Empirical evidence of the effect of an intrinsic orientation to work on time spent working is provided by Young and Willmott who show that managers and professional people who work overtime do so feeling that 'my work is my hobby', that they must 'lock in' at weekends to see 'if everything's going as it should be'.

98. R. Eubin: op. cit.

99. An occupational community is defined by Blauner (R. Blauner: Work Satisfaction and Industrial Trends in Modern Society in W. Galenson and S.M. Lipset (eds): Labour and Trade Unionism, 1960) as having the following characteristics:
   a. workers in their off-hours socialise more with persons in their own work than with a cross-section of occupational types;
   b. its participants talk shop in their off hours;
   c. the occupation itself is the reference group: its standards of behaviour; its system of status and rank, guide conduct.


104. ibid. p. 104.

105. D. Lockwood: op. cit.

106. E. Hughes: Men and Their Work, 1958 (p.43).

107. The diffuseness of the occupational role may be illustrated by deCallier's prescriptions for the diplomatist. He writes: 'The diplomatist must... bear constantly in mind both at work and at play the aims which he is supposed to be serving in the foreign country and should subordinate his personal pleasure and all his occupations to their pursuit, quoted by A. Hochschild in The Role of the Ambassador's Wife in Journal of Marriage and the Family, February 1969 (p.75).
Chapter II: Research Strategies

1. These included the perusal of the literature on occupations and interviews with personnel managers and representatives of professional associations and individuals in 'likely' occupations.

2. The career situation of hospital doctors is fully explored in Chapter IV.


5. The occupational situation of the general medical practitioner is similar to that of the general dental practitioner and, correlativey, different from that of the hospital doctor in terms of (a) the pattern and security of earnings (b) geographical stability and (c) isolation of the workplace but workloads, I believed when working out my research design, extend beyond the 'standard' working week, and are irregular. It was for this reason that I chose general dental rather than general medical practice as a foil to hospital medicine. I now believe that workload constraints may not, as a result of the growth of group practice, be as heavy as I had imagined. Various studies (summarised in a Royal College of General Practitioners' report: Present State and Future Needs of General Practice. Table 16, p.22) suggest that the general practitioners' working week varies between 34 hours and 42 hours. So, in retrospect, I wish that I had looked at general medical practice as this would have provided a direct contrast between the orientations to work and family of men in the same occupation who had chosen between two 'career' situations making contrasting demands and offering different rewards.

6. The decision to include in the study doctors holding non-research posts in clinical departments of the university was based on the following considerations:
   a. A substantial percentage of doctors working in hospitals in Edinburgh are in fact university employed; 33 of the 109 senior registrar posts in the South-Eastern Region, Scotland are University posts;
   b. Senior Registrars employed by the N.H.S. in Edinburgh teaching hospitals have honorary university status, and conversely university employed men have honorary status in the N.H.S.;
   c. The university system is used as an alternative career ladder by some doctors, and some switch from one to the other without markedly changing their duties.

Broadly speaking, senior lecturer status in the University system is equivalent to consultant status in the N.H.S. system, lecturer status to registrar status and assistant lecturer status to S.H.O. status.
Notes to Chapter II.

7. In hospital medicine, entry to the registrar grade and departure from the senior registrar grade is, in general, likely to take place between 3/4 - 12/14 years after graduation. Thus in both professions roughly the same time period after graduation was covered.

E. Pott: Family and Social Network, 1957. (chap. 3).

9. In particular, it has been shown that domestic tasks become less sharply defined as either man's or woman's work and that decision-making may be influenced in various ways. For a résumé of work in this area see L. Benson: Fatherhood, 1968 (pp 293-305).

10. In that both hospital doctors and general dental practitioners are in the Registrar General's Social Class I.

11. In that both hospital doctors and general dental practitioners have had a university education. It was thought desirable to have some measure of control for education and social class since these variables are generally assumed to have explanatory power.

12. See p. 44.

13. The Edinburgh area was defined as being within a radius of seven miles from the City centre.

14. In 1969 there were 3023 persons per dentist in Edinburgh. This represents a somewhat lower ratio of persons per dentist than that found in other Scottish cities (Aberdeen, Dundee and Glasgow) or in the South East Region, England. The South East Region has a lower ratio of persons per dentist than any other region in England and Scotland. (Sources: figures supplied me by the Scottish Home and Health Department and The Department of Health and Social Security Report, 1969, Cmd 4462 p. 172).


16. It was frequently nearly midnight when I returned home.

17. These included the postponement at short notice of appointments by respondents because of illness or work and, on occasion, the forgetting of appointments.

18. The lists used excluded those doctors and dentists who had been approached during the pilot study. Doctors and dentists in the pilot study were located on the basis of personal contacts.

19. That is of all doctors who had not been approached in the pilot study.
20. It is possible that some hospital doctors and dentists denied belonging to the desired categories rather than refuse an interview. I can only say that before I embarked on the study two hospital doctor contacts estimated, on the basis of their knowledge of the family status of their colleagues, that approximately two-thirds of the registrars and one half of the senior registrars would not fall into the desired categories. The percentage of doctors who in fact denied falling into the desired categories accords with this estimate.

21. That is all those dentists who had not been approached during the pilot study.


28. ibid. p. 6 - 7.

29. This usage of open and closed questions is fairly well-established. See A.N. Oppenheims Questionnaire Design and Attitude Measurement, 1966 (pp. 40-44).

30. Contamination occurred not only because husband and wife discussed the interview with each other but because hospital doctors discussed it with each other. This kind of contamination is inevitable when researching a close-knit colleague group.


32. Because of the interest expressed, I in fact promised to send respondents a summary of my main findings. A few respondents have written to me to enquire about the progress of the project.

33. In some cases this may have meant that doctors tended to stress their 'grievances'. Given this, it is interesting to note that the grievances that are stressed are not heavy workloads and high mobility, but uncertainty regarding the future and low earning power in the junior grades.
Notes to Chapter II

34. This was particularly true of the psychiatrists in my sample. And of one wife who was trained as a sociologist.

35. This must be qualified. Respondents seemed honest in their responses to open-ended questions, but I am less sure about their responses to structured questions. Structured questions, by their very nature, invite conventional responses. But to fabricate dishonest answers to open-ended questions is not easy, and it seemed to me that, where 'true' responses to open-ended questions were painful, respondents were brief rather than dishonest.

36. Reticence in talking about their marriage relationships is also reported on by Moya Woodside (Patterns of Marriage, 1951, pp.23-4) Mirra Kamerosky (Blue-Collar Marriage, 1962 p.14) and Marie Corbin who interviewed the Pahls' respondents (J.M. & R.E. Pahl: Managers and Their Wives, 1971). It is possible that this embarrassment was greater than it would have been had they been interviewed by a male interviewer, but if husbands are reticent about their marriages in the presence of a female interviewer and research findings are thereby biased, it is also probable that men are less likely to talk easily to a male interviewer about the expressive area of the marital relationship and more likely to simulate those attitudes to women that seem to be de rigueur in public bars and the changing rooms of rugby clubs.

Chapter III: Occupational and Familial Values

1. Most studies of familial roles examine role behaviour rather than role expectations. But it seems to me to be important to examine expectations as well as behaviour and thus to delineate the disjunctions that may exist between expectations and performance, and the tensions that may result.


3. Respondents were asked to place each item on a five-point scale on which 1 = very important and 5 = of little importance. As very few respondents gave any item scores of 4 or 5, these two categories were combined when analysing the data.

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Notes to Chapter III

3. Cont.
A 5-point scale was chosen as the pilot study suggested that respondents are reluctant to admit not attaching importance to items they believe to be generally highly valued. So, it seemed to me that scores of 3 and 4 (indicative of a low evaluation) might be more readily given if respondents were presented with a 5-point scale rather than a 3-point scale. In the text scores are interpreted in the following way:

1 = very important/greatly valued,
2 = important/moderately valued,
3 = fairly important,
4/5 = of little importance.

4. See, for example:
M.C. Morse: Satisfactions in the White-Collar Job, 1953.

5. The general high evaluation of self-fulfilment provides yet more supporting evidence for the thesis so frequently advanced in the literature that the professional middle classes define work as self-expression. See p. 25 ff.

6. The different expectations of work of hospital doctors and general dental practitioners may, possibly, represent rationalisations of their different occupational experiences. That is, their different valuations of, for example, income rewards may be the product of differences in their earning power (described in Chapter IV). If this is so, then orientations to work cannot be treated as independent of occupational experiences. But if it is, it seems to me, unlikely that orientations to work will be the product simply of experiences in the workplace.
For men, in fact, choose their occupations and their occupational situations. As I shall show later (in Chapter IV), doctors in particular have disparate career paths open to them and the fact that they choose one rather than the other has to be explained. The choice that they make is presumably made in the light of expectations and aspirations which they bring to the workplace and which are formed within the community. This must be particularly true of young men at the beginning of their careers. This argument is in line with that advanced by the authors of The Affluent Worker studies (J.H. Goldthorpe: Attitudes and Behaviour of Car Assembly Workers in British Journal of Sociology, vol. 17, 1966; J.H. Goldthorpe et al: The Affluent Worker and the Thesis of Bourgeoisement in Sociology, vol. 1, 1967 & J.H. Goldthorpe et al: The Affluent Worker: Industrial Attitudes and Behaviour, 1968).
Notes to Chapter III

7. The general low evaluation of, on the one hand, the opportunity to be of service to the community and, on the other hand, of job prestige is unexpected. The low evaluation of the opportunity to be of service to the community, seems to indicate that the service ideology so frequently attributed to the professions (T. Parsons: The Professions and Social Structure in Essays in Sociological Theory, 1949) is at a low ebb, at any rate in these two professions at this point in time.

The low evaluation of job prestige, as defined by the importance of having a job people think well of, may be a function of the question asked. Respondents may have scored this item in terms of the prestige of different jobs within the occupation of medicine or dentistry rather than in terms of the prestige of medicine and dentistry. Or it may be that they were reluctant to admit that what people think mattered to them - this is suggested by their comments.

In the pilot study I asked people to rate the importance they attached to 'prestige'. This elicited low evaluations; so I changed the wording of this item but evidently to no purpose.

8. This is implicit in Dubin's discussion of intrinsic and instrumental orientations to work (R. Dubin: The World of Work, 1958, pp.254-7), and, as I have already suggested, in the analysis of the behaviour of affluent workers (see note 6 above).


10. See pp. 124-126.

11. For the evaluation of both husband and wife roles, respondents were asked to place each item on a five-point scale in which 1 = very important and 5 = of little importance. As few respondents gave any item scores of 4 or 5, these two categories were combined for the purposes of analysis. As with the evaluation of work rewards, scores have been interpreted in the text in the following way:

1 = very important/greatly valued,
2 = important/moderately valued,
3 = fairly important,
4/5 = of little importance.

See note 3 above for my reasons for using a 5-point scale.

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Notes to Chapter III

11. Cont.
It should be noted that caution is needed in the interpretation of results. Structured questions invite conventional replies, and convention may often have resulted in parental and emotional support aspects of husband/wife roles being rated very highly. Thus a score of 2 may in fact be indicative of a fairly low evaluation of these dimensions of husband/wife roles. Conversely, both husbands and wives seemed to feel a certain difference in rating the provider aspects of the husband role high, and husbands in rating wifely support for occupational aspirations high. In these circumstances, a score of 2 may in fact be indicative of high expectations. This is illustrative of the difficulty which besets all sociological analysis. Questions may be structured but responses may not be valid because different meanings may be attached to the same response category.

12. But here it is interesting to note (a) that companionship is more highly regarded by the mobile hospital doctors and their wives than by the geographically stable dentists and their wives and (b) that in both groups companionship tends to be more highly regarded by wives than by husbands. These differences are discussed later in this chapter.

13. It should be emphasised that the differences between doctors and dentists are not differences in which, for example, companionship, is seen as important by one group and not important by another group, but differences in which companionship is seen by one group as very important and by another as important.

14. The suggestion I am here making of a relationship between the definition of breadwinning as a very important aspect of the husband role and the high evaluation of the economic rewards of work is corroborated when the individual’s valuations are examined. In the combined samples, 74% of those men (n = 39) giving the breadwinning role scores of 1 or 2 also give income rewards scores of 1 or 2, and 54% of those men (n = 13) giving the breadwinning role scores of 3 or 4, also give income rewards scores of 3 or 4.

15. To confuse matters, within the sample of hospital doctors, those doctors who define the breadwinning role as important are also likely to define wifely support for career goals as important. Twenty two of the 26 doctors who give breadwinning a score of 1 or 2 also give wifely support a score of 1 or 2.

Chapter IV: The Problem of Income Earning Potential


3. On graduation, all doctors spend one year in two house officer posts in approved hospitals so as to become eligible for full registration with the General Medical Council. For doctors who remain in the hospital service, the normal pattern of progression is through the grades of senior house officer, registrar and senior registrar.

4. The First Report of the Joint Working Party on the Organisation of Medical Work in the Hospital Service in Scotland (para 87), HMSO 1967. The number of posts in the senior registrar grade is in fact related to the number of potential vacancies in the consultant grade, a strategy adopted by the Health Departments to solve the problem of the time-expired senior registrar. However, control at this point has merely shifted the point at which the promotion bottle-neck occurs.

5. This estimate is supported by Last and Stanley's finding that the number of doctors planning to enter the main specialties is double the possible number of potential vacancies for senior appointments in these fields. (G.V. Last and C.R. Stanley: Career Preferences of Young British Doctors, in the British Journal of Medical Education, Vol. 2, 1968). Similarly a report of the South-Eastern Regional Hospital Board, Scotland (Junior Hospital Medical Staff Survey 1968-69, paras 45-50) shows that while 194 N.H.S. employed post-registration house officers and registrars in the region plan to remain in the hospital service, there are only 76 N.H.S. senior registrar posts and 33 honorary (university) posts in the region and some of these will not be filled by N.H.S. staff.

It must, however, be born in mind that the dilemma of, on the one hand, relative numbers to promotion opportunities and, on the other hand, of providing the numbers required for service needs is eased by the increasing tendency of young doctors who do not intend to make a career in hospital medicine to remain in the hospital service for some time after registration so as to gain experience before going into general practice.

It is also eased by the presence in the hospital service of a substantial number of overseas doctors who intend to return to their own country of origin after completion of their training.
Notes to Chapter IV.


8. Statistics for England and Wales supplied to me by the Department of Health and Social Security, and for Scotland by the Scottish Home and Health Department.

9. Limitation on tenure of appointments in these grades is governed by the need to ensure that there will be sufficient openings for new graduates to enter the house officer grade so that they may qualify for registration, and for registered doctors to obtain the experience they need at different levels and in different specialties. Doctors may hold successive posts in the same grade.


12. ibid. para 92.


14. It is for this reason that some university-employed clinical staff were included in my sample. University-employed medics are subject to the same conditions of service as other teaching staff and thus (apart from those on short-term research contracts) enjoy greater security of office than N.H.S. doctors. On the other hand their chances of reaching the top of the university career ladder (that is of holding a chair) are more slender than the N.H.S. employed-doctor's chances of obtaining a consultant post. Some idea of the chances of holding a chair may be gauged from the fact that in 1972-73 only 18.5% of the 2,653 doctors on clinical academic staff establishments in the U.K. were professors. A further 33.4% were readers and senior lecturers. (Statistics supplied me by the University Grants Committee.)
Notes to Chapter IV.

14. Cont...
The extent to which doctors move between the university system and the N.H.S. system may be gauged from the fact that four of the nine lecturers in my sample were either about to, or actively engaged in, the attempt to return to the N.H.S. in a consultant position. Of the 29 N.H.S. doctors in my sample, two had, in the past, held university research posts and four had held 'filler' posts as demonstrators.


16. Since 1960 levels of remuneration in the Health Service have stemmed ultimately, from the recommendations of the 1977-60 Royal Commission on Doctors' and Dentists' Remuneration (Pilkington). The Royal Commission sought - unsuccessfully, it would appear, as far as junior hospital doctors are concerned - to make remuneration within the N.H.S. compare favourably with remuneration in other professions.

17. Before 1948 house officers accepted appointment virtually in an honorary capacity, being given only their board and lodging and a laundry allowance. As a result, a career in hospital medicine was confined to those able and willing to support themselves from their own resources during the lengthy training period (Report of the Working Party on the Responsibilities of the Consultant Grade (para 9), HMSO 1969.

18. See pp. 75 - 76.

19. Doctors' and Dentists' incomes are reviewed periodically by a Standing Review Body. The first of these bodies was set up under the chairmanship of Lord Kindersley on the recommendation of the Pilkington Royal Commission. The second was set up in 1971 under the Chairmanship of Lord Halsbury - see note 22.


21. The salaries of academic clinical staff are broadly comparable with those of N.H.S. staff and, in fact, since 1970 academic salaries have been based on those of doctors in comparable grades in N.H.S. employment. In 1969, the year of the study, salary scales were as follows:

Professors: up to £5,275.
Lecturers, Senior Lecturers and Readers with honorary consultant contracts: from £3,470 to £5,275

/Cont...
Notes to Chapter IV.

21. Cont...
Staff not holding honorary contracts:
Senior Lecturers and Readers within the range £3,020
of maximum for Lecturers £2,920
Lecturers minimum from £1,590
to maximum to £4,280

22. This recommendation was to cover a two-year period, 1970-1972, and therefore took into account both short falls in levels of pay in the 1960s and a projected rise in the salary index so as to allow doctors' and dentists' salaries to be 'right' (when compared with other salaries) as at March 1971 (the mid-point of the forthcoming review period). In fact the government of the day considered this recommendation to be at odds with the Incomes Policy then in force and referred it to the National Board for Prices and Incomes. The upshot of this was that the Kingersley Review Body resigned, doctors and dentists in the training grades received an increase of 30% and other doctors and dentists an increase of 20%. A new Review Body under the chairmanship of Lord Halsbury was appointed in 1971. This body recommended an increase of 3% for those who had received 20% in 1970 and left the income of junior hospital doctors unchanged. Thus the position from April 1971 onwards was virtually what it would have been if the 1970 recommendations of the Kindersley Review Body had been implemented in full.

23. The disparity between improvements in hospital doctors' salary scales and the upward movement of the DE Salaries Index is even greater. In the period between 1960-1961 and 1971 hospital salaries increased by 83% while salaries generally increased by 102%. The Salaries Index is compiled from information about the earnings of workers who are relatively low paid in relation to doctors and dentists and in recent years lower incomes have generally tended to increase at a faster rate in percentage terms than higher incomes. See the Report of the Halsbury Review Body on Doctors' and Dentists' Remuneration, Cmnd 5010 (paras 35-38), HMSO 1972.

24. Consultants may be employed on a full-time or part-time basis. Part-time consultants are at liberty to undertake private practice.

25. A claim made in representations to the Kindersley Review Body - see the Twelfth Report of the Kindersley Review Body on Doctors' and Dentists' Remuneration, Cmnd 4252, (para 94), HMSO 1970. It must also be noted that the Regional Hospital Consultants' and Specialists' Association say that, although some consultants may earn in excess of £20,000 a year, the extra income earned by consultants averages out at only £1,000 since opportunities for private practice in many specialties is limited (Daily Telegraph report, February 14, 1973).
26. For doctors living and working in Edinburgh, financial pressures are intensified by the perceived desirability of private schooling.

27. This disjunction between the pattern of family economic needs and income rewards for the job has been commented on by Wilensky. (H.L. Wilensky: Life-cycle, Work Situation & Social Participation in C. Ribbitt & W. Donahue (eds.), Social & Psychological Aspects of Aging, 1962.) But, as I shall show in a moment, this disjunction between work and family is not found in some middle-class occupations. Manual workers, it may be noted, may and do increase their earnings to meet family demands at this stage of the life-cycle by shiftwork (See M. Young and P. Willmott: The Symmetrical Family, 1973 (p.183-4); and the National Board for Prices and Incomes Report No.161: Hours of Work, Overtime and Shiftworking, Cmnd 4554 (p.25), HMSO 1970.

28. See p. 18.

29. I describe here the career structure of general medical practice because it represents an alternative career path for young doctors that is compatible with family life. Given this, the situation in which hospital doctors find themselves has to be looked at in terms of their expectations of work and the place which work plays in their life interests. This is considered later — see pp. 106-109.

30. The career structure of general dental practice is similar to that of general medical practice and, correlatively, both are different from hospital medicine in broadly similar ways. My reasons for examining general dental practice rather than general medical practice as a foil to hospital medicine were discussed in Chapter II (note 5, p.270).

31. The Last and Stanley Study shows that in 1966 only half as many young doctors wanted to enter general practice as the number needed to maintain the strength of general practice (J.M. Last and G.R. Stanley: Career Preferences of Young British Doctors, British Journal of Medical Education, vol.2, 1968.). Similarly a report of the South-Eastern Regional Hospital Board, Scotland, shows that while the South-Eastern Region might be expected to produce 31 principals for general practice each year, only 17 junior hospital doctors in the region planned to enter general practice (Junior Hospital Medical Staff Survey Scotland, 1968/69, paras 45-50).

32. This is suggested by the Kindersley Review Body on Doctors' and Dentists' Remuneration in their Seventh and Twelfth Reports (Cmnd 2992 paras 223-231, HMSO 1966 and Cmnd 4352 paras 64-74, HMSO 1970, respectively).
Notes to Chapter IV.

33. Doctors intending to enter general practice usually do so after spending about two experience-gaining years in the hospital service. Once in general practice, they normally do 3-6 months assistancehip with a view to partnership, reaching full parity after an average of three years. Dentists usually go into general practice as assistants or associates immediately on graduation. After an experience-gaining period, they become associates, partners or principals. General practice represents the major career path for dentists. A few go into the hospital service where the staffing structure and rates of pay are similar to those of hospital doctors and a few go into local authority dental services or into the Services.

34. Doctors’ incomes are based on a practice allowance, standard remuneration, and special fees for services earned in pursuance of public policy, with additional payments for undertaking services at nights, for practising in unattractive areas and for vocational training and special experience. Since 1966 the Review Body has recommended levels of payment for services rendered and, in making their recommendations, have aimed at producing a specified average net income. Prior to 1966, the Review Body prescribed only an average net income. This, plus a sum intended to represent practice expenses, was then credited to a Central Pool. Fees and practice expenses were then paid out of the pool to the individual practitioner at rates agreed by the profession and Health Departments.

35. There is, if anything, a tendency for earnings in general practice to decline in late middle age when the pace of work can no longer be maintained, as Table 4:8(a) shows. Because of this seniority payments were introduced in 1969.


37. Comparisons of career earnings are based on the application of 1969 incomes to lifetime earnings.

Comparisons are also based on the assumption that, typically, a doctor completes his pre-registration year by age 26 (Report of the Royal Commission on Medical Education, Cmd 3569 para 123, HMSO 1968) and spends 2 years in the senior house officer grade at which point he either enters general practice (where he will spend up to a year as an assistant or trainee before obtaining a substantive appointment) or remains in the hospital service, obtaining consultant status at 38 (the average age at which consultant status was obtained in 1969 - see p.76).
Notes to Chapter IV.

37 Cont...
There is, however, considerable variation in career patterns and it should be noted that in Scotland in 1969 43% of SHOs were 30 and over, 35% of registrars were 35 and over and 17% of senior registrars were 40 and over. (Statistics supplied to me by the Scottish Home and Health Department.) Dentists typically enter general practice at about age 23 (Report of the Halsbury Review Body on Doctors' and Dentists' Remuneration, Cmd 5010, para 16, HMSO 1972) and in general are probably approaching their earnings peak before age 28. The Tables therefore understate the dentists excess earnings in the early stages of the career cycle given that they are, in their mid 20s, earning substantially more than the hospital doctors of equivalent age.

38 Over the life-span, the hospital doctor who remains on the basic salary scale will earn, on average, £418 a year more than the general medical practitioner and £637 a year more than that of the general dental practitioner.

39 As Table 4:3 (a) shows.

40 This is the figure shown in all the comparisons as the income of doctors in general practice aged 28. As the Assistantship period usually lasts 3–6 months, this figure understates the amount earned at this age. On the other hand, average net income figures of all general practitioners or average advertised earnings on first substantive appointment would substantially overstate earnings at this age, so this figure is used. The Halsbury Review Body's 1972 Report does not cite earnings of assistants.

41 Ns = 64, 57 and 51 respectively.


43 The following analysis is based on responses by wives to the probing that followed the following open-ended question: 'I am particularly interested in the different things different people aim at in life. Can we begin by talking generally about your main aims in life.' and 'In what ways, if any, has your family life, yours and the children's, been affected by your husband's work commitments?'

Notes to Chapter IV.

45. See p. 119.

46. As Townsend has so forcefully argued.

47. Respondents were asked: 'Why did you choose the hospital service rather than some other branch of medicine?' Respondents seemed to see their choice as lying between general practice and hospital medicine - as indicated by the fact that they rarely referred to other branches of medicine.

48. These attitudes may, possibly, represent rationalisations of their present situation. But I do not think so, given that these men had chosen their situation (doubtless within the context of a particular professional culture) and the younger registrars still have the option of changing their situation by entering general practice.

49. See p. 59.

50. It must be noted that 87% of doctors in my sample were married within a year of registration.

51. As will be seen, this legitimating ideology was frequently voiced by both husbands and wives in varying contexts. It is further discussed in Chapters VII and VIII.

52. Attitudes to living standards and the system of remuneration were revealed in discussions of aims in life following the question: 'I am particularly interested in the different things different people aim at in life. Can we begin by talking about your main aims in life?', and by probing on earning power following the question: 'In what if any ways has your family life, your wife's and the children's, been affected by work commitments?' and 'In what, if any, ways has your work life been affected by family commitments?'

53. In some cases material aspirations may have been stimulated by family responsibilities. This is suggested by the fact that two men said that money had come to mean more to them since marriage.

54. Discontent with conditions of work was expressed by 16 men.
Notes to Chapter IV.

55. See pp. 59 - 60.
56. See pp. 59 - 60.
58. Dentists were asked: 'Why did you choose general practice rather than some other branch of dentistry.' In considering responses to this question, it must be remembered that dentists have not the scope for choice that doctors have in that opportunities outside N.H.S. general practice are limited.
59. This view was occasionally expressed by my respondents. See also a Daily Telegraph report of August 3, 1972.
60. Satisfaction with living standards was expressed at various points in the interview by 96% of the sample.
61. Expressed by 13% of the sample.
62. Expressed by 69% of the sample.
63. The following analysis is based on expressions of discontent voiced at various points in the interview but in particular in response to the probing which followed the question on respondents' 'aims in life'.
64. Hospital doctors seemed also to express positive satisfactions in their work more frequently. Expressions of positive satisfactions have not been systematically analysed.
65. See p.66.
66. See p.60.
67. These views were explicitly stated by 19 wives. But it must be noted that I have, by virtue of my research design, 'missed' wives who may have 'pressurised' their husbands into general practice.
68. See p.66 and p.60.
69. See p.97.
70. See p.60.
71. This view was expressed by 4 wives.
72. The following analysis is based on husbands' and wives' responses to the probing that followed the question on the consequences of work commitments for family life.
Notes to Chapter IV.

73. This is not, of course, an estimate of the extent to which hospital doctors and their families may use this strategy for supplementing incomes since (a) respondents were not systematically probed as to whether or not they had in the past worked after the arrival of children for financial reasons and (b) the sample specifically excluded working mothers.

74. That is help from parents either of the doctor or of his wife.

75. Bell suggests that the giving of presents on socially approved occasions is a mechanism whereby parents may give aid without loss of independence or feelings of obligation on the part of the recipient. (C. Bell: Middle Class Families, 1969, p.93).


77. C. Bell: Middle Class Families, 1969 (pp.87-93). Bell also suggests that the phenomenon of parental aid points to the structural importance of the father-son relationship in the middle class family in that it is through this link that aid flows from generation to generation. Consequently, he says, the suggestion made by both Willmott and Young (Family and Class in a London Suburb, 1960) and by Rosser and Harris (The Family and Social Change, 1965) to the effect that the key relationship within the extended family is that consisting of wife's mother-wife-husband-husband's mother must be qualified.


81. Successive reports of the Review Body provide a lively record of the arguments the B.M.A. has used in its attempts (sometimes successful, sometimes unsuccessful) to obtain salary increases for different groups of doctors, and of the justifying by different groups of doctors for advantaged positions vis-a-vis other groups of doctors and professionals.
Notes to Chapter IV.

32. The extent to which doctors support the policies and activities of the JHDA is evidenced by the fact that it has a membership of 5,500 doctors.

33. As will be seen their objectives and activities refer not only to modifying the structure of opportunity found in hospital medicine but to improving their conditions of work generally. For the sake of completeness I mention here all their main objectives and activities.

34. The Medical Assistant Grade, a sub-consultant grade of unlimited tenure was created in 1964 on the recommendation of the Platt working Party so as to meet Service needs while providing employment on a permanent basis in the hospital service for registrars and senior registrars who do not proceed to consultant appointments. But the Grade proved unpopular with hospital doctors by virtue of the conception of the medical assistant as an assistant to a consultant who may not treat cases without reference to his senior (Report of the Royal Commission on Medical Education, Cmd 3569, para 48, HMSO 1968).

35. One of the hospital doctor's complaints is that contracts vary with employing authorities.


37. It should be noted that collective action for the improvement of conditions of work is not limited to junior hospital doctors. Consultants are also campaigning (largely through the Regional Hospital Consultants' and Specialists' Association) to improve their conditions of work and advance their earning power. Their activities do not come within the province of this thesis.

38. See pp 105 - 108.

39. See Chapter I.
NOTES

Chapter V: The Problem of Geographical Mobility

1. See Appendix to this chapter, p. 150, for the conventions adopted in determining rates of mobility.

2. Defined as those born and/or schooled in Edinburgh or the Lothians.

3. Mobile respondents were asked: 'What considerations affected your decision to live in Edinburgh?'. Non-mobile respondents were asked their reasons for not moving from Edinburgh.

4. Environmental considerations included references to architectural and scenic beauty, cultural and social facilities, accessibility of the sea and the open country, and the non-industrial character of Edinburgh.

   Family considerations, refer to the desire to be near husbands' or wives' families of origin, the desire to enable wives to continue in jobs they enjoy, the restrictions placed on moving by having a family and house.

   Social considerations refer to the desire to maintain contact with friends (including girl friends who were later to become wives).

   Nationalistic considerations refer to the desire to remain in Edinburgh on patriotic grounds.

5. Probing on this matter followed the question: 'In what, if any, ways has your work life been affected by family considerations?'

6. The discussion that follows is based on an analysis of the reasons given for living in Edinburgh.

7. In effect the general dental practitioner is a 'burgess' and the hospital doctor a 'spiralist'. For discerning accounts of the relationship between the structure of opportunity of these two categories of people and their mobility experiences and orientations to the local community see C. Bell: Middle Class Families, 1969 and M. Stacey: Tradition and Change, 1961.

8. The general medical practitioner's position is similar to that of the general dental practitioner in that for him, too, geographical stability follows from the need to build up a local reputation and clientele. Thus, Butler found that just over 40% of family doctors in his sample were still working in the practices in which they had started and that few move more than once. (J.R. Butler: Family Doctors and Public Policy, 1973, p. 53)

Further, Last has noted that general practitioners are more likely than consultants to settle in the part of the country in which they lived in their youth and, if priorities conflict, more often choose to live in a desired locality while hospital
Notes to Chapter V.

8. Cont.
doctors more often value the pursuit of career ambitions. (J.M. Last: Regional Distribution of General Practitioners in the N.H.S. in British Medical Journal, 24 June 1967, p.796ff)


10. The implication here is that there is no reason why the family should not endure disliked conditions where these are of a short-term character. But it is important to note that hospital doctors may be in successive temporary jobs for a period of 12-14 years.

11. Theoretical expositions of the 'fit' between the nuclear family system and modern occupational systems (cited in Chapter I) seem to assume that any stress that mobility may generate for the family will be resolved by the marital partnership. My investigation of the consequences of mobility for family life suggest that this is not necessarily so.

12. One of these cases was mentioned by both husband and wife, and one by the wife only.

13. In fact the number of parents reporting that their children were in any way affected by mobility is very small. This parallels Barrett and Noble's findings (C.L. Barrett & H. Noble: Mothers' Anxieties versus the Effects of Long Distance Move on Children in Journal of Marriage and the Family, May 1973). Barrett & Noble suggest that parents' perception of mobility as having negative effects on children is related to their own 'bad' attitudes to moving. This could also be true of those of my hospital doctors and their wives who regard mobility as unsettling for their children.

14. The classic statement on the isolating effects of mobility is still Young and Willmott's Family and Kinship in East London (1957). Young and Willmott dealt with working-class people and the effects of mobility generated by rehousing. For treatments of occupation-generated middle-class mobility, see, for example, C. Bell: Middle Class Families, 1969 (chap.4) and J.M. & R.E. Pahl: Managers and Their Wives, 1971 (chaps. 3 & 6).


16. It is interesting to note that some incoming respondents have kin living nearby. This is perhaps a reflection of the fact that Edinburgh is a capital city which tends to draw within its orbit professional people from other parts of Scotland. This finding suggests that in considering the impact of mobility on kinship relationships we have to consider not only the fact of mobility but also the drawing potential of the places to which they move.
Notes to Chapter V.

17. Mobility is not, of course, always isolating. As Table 5:4 showed, 11 of the 29 mobile doctors' wives did not find mobility productive of isolation. Some wives may be only too pleased to get away from relatives in a small town situation which they find claustrophobic, and in some cases links with the receiving community may be easily forged. A wife may find some moves problematic and other moves non-problematic.


21. This man seemed oblivious of the fact that his wife, though she accepted mobility, did not enjoy it.

22. Some wives seemed to experience greater distress than others as a result of the structured incompatibility that exists between the occupational system and the family system in terms of geographical mobility. In Chapter VII an attempt is made to account for this differential experience of distress.

It should also be noted that I was sometimes told, with evident disapproval, of wives known to respondents who had pressurized their husbands into general practice so as to avoid geographical mobility. My research design unfortunately misses wives who did this.


Chapter VI: The Problem of Heavy Workloads

1. The term 'leisure' is here used to denote non-working time.

2. Normal hours of work are not precisely defined and vary from hospital to hospital. The Management Services (NHS) study on the Organisation of the Work of Junior Hospital Doctors (H.M.S.O. 1971) suggests that 'normal hours' are usually from 9:00 a.m. to 5:30 p.m. excluding the weekend. Easton treated normal hours as 9:00 a.m. to 5:00 or 6:00 p.m. (I.D. Easton: Review of Hospital Junior Medical Staff in the Eastern Region of Scotland, 1969).


4. Junior Hospital Medical Staff Survey 1963/69, a report of the South-Eastern Regional Hospital Board, Scotland (paras 55-57).
5. Ibid, para 59.
   The findings of the Hospital Board may be compared with those of a survey of a Northampton General Hospital which showed that 36% of staff in that hospital receive off-duty time that was 'about the same as' or 'more than' the recommended amount, while 35% received 'slightly less' and 29% receive 'much less' than the recommended amount. (M.R. Redman, J.P. Toby, J.R. Peniket: Hospital Junior Doctors: Survey at Northampton General Hospital, British Medical Journal, 30 August 1959, pp 552 - 555.)


7. Two recent studies throw some light on differences in workloads between specialties. Walker, Miller and McLean show that doctors in Orthopaedics and Casualty and General Medicine and Registrars in Surgery spend a higher proportion of their time when on night or weekend duty working than doctors in Geriatrics, Paediatrics, ENT and Ophthalmology. These three specialties also had the greatest number of emergency calls.
   (R.G. Walker, W.R. Miller and J.G. McLean: A study of the workload of Hospital Junior Medical Staff at Victoria Hospital, Kirkcaldy, in Health Bulletin, Jan. 1970). The Northampton study referred to earlier (note 5) shows that doctors in General Medicine, Obstetrics and Gynaecology, Orthopaedics and Accident and Emergency wards were under heavier pressure than those in Surgery, Anaesthetics, Paediatrics, ENT or Ophthalmology.

8. This is shown in two recent studies. The study by Walker, Miller and McLean, referred to earlier (note 7), shows that during the fortnight in which they studied the workload of junior hospital staff at a general district hospital in Scotland, house officers received 298 emergency calls (17.1 per doctor) while registrars received 53 emergency calls (4.0 per doctor) and consultants received 3 calls. Nightingale and Taylor show that the amount of time spent in hospital by junior anaesthetic staff at a London hospital decreases with seniority. The amount of time on call also decreases with seniority until the senior registrar grade is reached. In this grade the amount of time on call is nearly as high as in the houseman grade. However, the senior registrar unlike doctors in other grades, was not required to be resident in hospital when on emergency duty (D.A. Nightingale, and T.W. Taylor, Work Study on Junior Anaesthetic Staff, British Medical Journal 14 May 1966, pp 1218-1220).


10. op. cit. para 151.
Notes to Chapter VI.


13. The factors impinging on workloads in general medical practice (the alternative career path rejected by hospital doctors) is in some respects similar to those found in hospital medicine. The general medical practitioner, like the hospital doctor, must provide a 24-hour a day service. A report published by the Royal College of General Practitioners (Postwar Stage and Future Needs of General Practice, 2nd ed. May 1970, cited by the Halsbury Review Body in its 1972 report, Cmd 5310, para 22) suggests that on a typical day the average C.P. works two consulting sessions at which he will see 16 patients at each session and will visit eight patients in their homes. He will be on call less than every other night and about every other weekend. However, a subsequent edition of this report (published March 1973) shows the total amount of time spent in work to be less than 40 hours a week.

14. The standard number of hours, which is based on the number of hours worked by the average dentist, was defined as 2040 hours per annum in the Second Report of the Kindersley Review Body on Doctors' and Dentists' Remuneration, published in the Official Report of the House of Commons, February 1, 1965.


16. Ibid. para 175.


The Royal Commission on Doctors' and Dentists' Remuneration intended that a reduction in gross fees for items of service would normally follow where the prescribed target average net income was substantially exceeded by the profession as a whole. Similarly, where the target average net income is not reached, an increase in gross fees is indicated. In the early 1960s adjustments were made to the scale of fees to keep pace with changes in the level of output. But the profession as a whole were opposed to reductions in fees, which they saw as depriving them of the rewards of increased productivity. In order to circumvent the necessity of reducing fees, the Review Body, when presenting their Seventh Report in 1966 (Cmd 2992 HMSO, London) made recommendations for a period of two years and recommended separate targets for each of the two years, with the target net income for the second year being higher than that for the first. This practice was adhered to until made unnecessary by the implementation of annual instead of two-yearly or three-yearly reviews.
It is relevant here to note that the Management Services (MHS) Study on the Organisation of the Work of Junior Hospital Doctors (HMSO, 1971) found that hospital doctors sometimes continued to work or returned to work, possibly to satisfy themselves about the conditions of their patients, even when not on call according to the rota. Similarly the South-Eastern Regional Hospital Board, Scotland, found that some hospital doctors felt that to be off-duty for a weekend (from Friday evening to Monday morning) was too long for continuing clinical care. (Junior Hospital Medical Staff survey 1968/69, para 55, a report of the South-Eastern Regional Hospital Board).

As evidenced by the very-ready adoption by dentists of time-saving work procedures and the steady reduction in working hours coupled with the persistent tendency to exceed target incomes.

Details of the classificatory system used and of the limitations of the diary method are given in an appendix to this chapter, p. 195. For the diary schedule see pp. 325-332. As diaries were kept and returned to me by only 34 of the 38 doctors, the following analysis is based on a sample size of 34 doctors. All 16 dentists returned diaries.

Work activities included time spent attending lectures or meetings in any way connected with work, working at home in the evenings or at weekends (i.e., for e.g., reading work-associated literature) and travelling time. See appendix to this chapter for further details.

The Ninth Report of the Kendersley Review Body on Doctors' and Dentists' Remuneration suggests that dentists' workloads average 2000 hours during 1966-67 (Gend 3600 para 176 HMSO 1969), or, on the basis of a 48-week working year, 41.6 hours per week. The average working week of dentists in my sample is 46 hours. The slightly longer working week here reported is almost entirely due to the inclusion of travelling time in the working week.

For comparisons of the workloads of junior hospital doctors and general dental practitioners with those of other professional groups, see p. 20, to chapter II. These findings may be compared with the findings of a survey at the Northampton General Hospital which suggest that a quarter of all doctors in the sample worked more than 70 hours during the week of the study and that the average number of hours worked was 59.7 hours. (N.R. Redman, J.F. Toby, J.B. Feniket: Hospital Junior Doctors: Survey at Northampton General Hospital, British Medical Journal, 30 August 1969, pp. 552-555).
Notes to Chapter VI.

26. But not a complete indication since some bookwork is done in hospital.

27. See appendix to this chapter (p.193) for activities defined as 'family activity' and as 'non-familial leisure'.

28. The maximum was 55 hours.

29. The minimum was 10 hours.

30. In looking at the consequences of increases in workload for participation in family life, what matters is the weight of the workload, not whether a man is a hospital doctor or a dentist. Hence hospital doctors and dentists are treated as a single group. It must, however, be remembered that with few exceptions men with workloads exceeding 60 hours are doctors and men with workloads of 60 hours and less are dentists.

31. Where men work between 41-50 hours, the average length of time spent in family activity shows a slight increase on the amount of time spent in family activity by men whose workload is 40 hours or less. Too much cannot however be read into this result as there are only 4 men in the latter category, two of whom, by the standards set by the sample as a whole, spent an unusual amount of time in non-familial leisure. This accounts for the apparently curious increase in family activity with increase in workload. To obviate the possible freak effects of sample size, we may treat as a single group those men whose weekly workload is 40 hours and less and those men whose weekly workload is 41-50 hours.

32. The specialties of these men were psychiatry, geriatrics and ophthalmology. By implication, men who enter what are generally regarded to be demanding specialties do so regardless of the demands they knew would be made on their time. In doing so they implicitly make a decision to allow work to dominate their lives.

33. Even while feeling that her children needed more of their father's company, this wife, like some others in the sample, felt that father absence is part of the professional way of life and that the example provided of devotion to work is desirable - it is good for children to learn early in life that work is important.
Notes to Chapter VI.

34. This suggestion was made by one husband—a psychiatrist.
   This may represent a rationalisation on his part. But, equally,
   a wife’s perception of her child as suffering from paternal
   deprivation may be the projection on to her child of her own
   frustrations. This seems likely to occur where wives regard
   the demands of work as legitimate, but nevertheless experience
   the consequent loneliness as intolerable.
   However, it is worth noting that there is a growing volume
   of work on the effects of father-absence on the development
   of the child. See, for example,
   L. Carlsmith: Effect of Early Father Absence on Scholastic
   Attitude in Harvard Education Review, vol. 34, 1964;
   D.B. Lyn & W.L. Sawrey: The Effect of Father-Absence on
   Norwegian Boys and Girls in Journal of Abnormal Social
   Psychology, vol. 59, 1955;
   W. Mischel: Father-absence and Delay of Gratification:
   Cross Cultural Comparisons in Journal of Abnormal and Social
   Psychology, vol. 63, 1961;
   F.S. Sears: Doll Play Aggression in Normal Young Children:
   Influence of Sex, Age, Sibling Status, Father’s Absence in

35. Deprivation of social life was referred to, but not elaborated
   upon, by 10 doctors. Accordingly this point is not elaborated
   upon by me either.

36. Though men frequently said, “my wife doesn’t see as much of me
   as she thinks she ought to,” they rarely said “I don’t see as
   much of my wife as I would like.”

37. 13 doctors stated explicitly that their wives had by their
   understanding and tolerance made the situation tolerable.
   15 doctors referred to their wives as resentful, angry,
   disgruntled or resigned. The remainder did not explicitly
   comment on wifely attitudes, though they sometimes referred
   to the difficulties experienced by them.

38. The two dentists whose workload exceeded 60 hours during the
   week under observation are not in fact among those dentists
   who regard their family lives as restricted by work.

39. As the Pahls (in Managers and Their Wives, 1971, chap. 8) and
   6 & 9) show, participation in family activity by managers and
   managing directors is also eroded by heavy workloads. Both
   the Pahls and Young & Willmott pay particular attention to
   lowered participation in domestic tasks. Although neither the
   Pahls nor Young & Willmott are systematic in their exploration
   of the effects of workloads (and, indeed, in focussing on the
   sharing of domestic tasks they focus on what is perhaps the
   least important dimension of the marital partnership), their
   work provides further evidence of the effects of heavy workloads
   on family life in another middle-class occupational group. Young
   & Willmott also suggest that shift-working may have the same effects
   at the working-class level.
Notes to Chapter VI.

40. See p. 117 - 118.

41. The following analysis is based on responses to the probing on workloads that followed the question on the consequences of work for family life.

42. The existence of rituals was reported by 11 wives.

43. Seven wives reported taking up outside activities.

44. Reported by nine wives.

45. Two wives reported using nursery schools for this reason.

46. As I have shown, heavy workloads 'squeeze' first non-familial leisure and then family activity (see p. 116).

47. See p. 169.

48. See p. 123.

49. Suggestions included getting a part time job, going to evening classes, joining a club, taking up voluntary work or bringing a lodger into the home so as to have other adult company. The development of outside interests should be possible since husbands could be used as baby-sitters. These suggestions imply an acceptance of segregation of leisure interests.

50. It is a little surprising that more husbands than wives subscribe to this view. It may be that in an interview situation husbands were reluctant to appear to be making heavy demands of their wives.

51. See appendices 3 & 4.

52. Respondents were told that 'colleagues' were to include all fellow doctors (for doctors) or dentists (for dentists) regardless of whether or not they were currently working with them and regardless of whether or not they regarded them as 'friends' rather than 'colleagues'.

53. Wives accounts of their activities have not in fact been analysed.
Chapter VII: The Tension between Work and Family.

1. Whereas entry into general practice would have brought them high earning power in the family-building stage of the life-cycle, geographical stability and low workloads.

2. I am here making a distinction between an objective social situation and the experience by individuals of that situation. There are situationally-structured incompatibilities or tensions between work and family but these tensions may or may not be experienced as stressful by individuals in that situation.

3. 53% of doctors' wives had in fact worked within the hospital service as nurses, physiotherapists or as medics themselves or were daughters of medics.

4. Simple expressions of dislike were not counted as negative feelings. My approach is similar to that adopted by Brown and Rutter (G.W. Brown and M. Rutter: The Measurement of Family Activities and Relationships in Human Relations, vol. 19, 1966).

5. Respondents were presented with five response categories: very sympathetic, sympathetic, fairly sympathetic, not particularly sympathetic and not at all sympathetic. Very few respondents placed themselves in either of the last two categories. Respondents comments suggested that 'sympathetic' responses indicated reservations and 'fairly sympathetic' responses indicated strain. I have therefore combined the last three categories to form a single category and have regarded both sympathetic and fairly sympathetic responses as evidence of tension.

6. For these accounts see chapter IV, V and VI.

7. Both husbands and wives were asked: 'All in all would you say that in your marriage things had turned out: very well, well, about average, badly, very badly?'

8. Husbands were asked: 'Would you say that your wife is sympathetic to how you feel about work?' and were presented with five response categories: very sympathetic, sympathetic, fairly sympathetic not particularly sympathetic, not at all sympathetic.

9. However, too much must not be made of this. For wives who are not very sympathetic with their husbands feelings about work may be very satisfied with marriage. Similarly, many husbands who perceive their wives as not very sympathetic with their work feelings may be very satisfied with marriage. But see also note 10.
Notes to Chapter VII.

10. The fact that there is slightly greater marital dissatisfaction among hospital doctors and their wives than among general dental practitioners lends support to the inference drawn from the relationship found between lack of sympathy and perceptions of lack of sympathy with husbands' feelings about work and marital dissatisfaction as to the importance of work-family incompatibilities in marital disharmony.

Supporting evidence of the effect of work involvement in leading to marital tension is provided by the Pahls' study of managers (Managers and Their Wives, 1971) and by Lotte Bailyn (Career and Family Orientations of Husbands and Wives in Relation to Marital Happiness in Human Relations, Vol. 23, 1970).

11. The situation of the dental wives will not be looked at. They cannot be grouped with the doctors' wives since the constraints impinging upon the dentists' working life are different from the constraints impinging upon doctors. At the same time they cannot be looked at on their own - it would be futile to attempt anything in the nature of generalisation on the basis of four high stress cases.


13. n = 34 since 4 respondents did not return diaries.

14. See Chapter IV.

15. But too much should not be made of this for the numbers in each cell are now very small.

16. With one exception the non-mobile wives who are distressed have two or more children, while seven of the ten non-mobile wives who are not distressed have only one child. This difference in family size, and therefore in the pressures experienced, may help to explain the distress among non-mobile families. It must be emphasised that the explanations advanced can only be tentative given the small size of the sample and the interaction of so many variables.

17. It is difficult to say with certainty that the objective pressures to which these wives were exposed are substantially lower than the pressures experienced by other wives. But it seems likely that they are for the reasons already explored: namely the conjunction of improvements in conditions of work consequent on seniority and of relatively light family demands following from a family size of only one. We may also note that, of the five wives in this group, four were non-mobile and four were married to men in specialties generally regarded as having a 'low emergency quotient'. Three of these men worked for less than 60 hours during the week under observation.
Notes to Chapter VII.

13. Wives of senior registrars are here excluded, as they were when considering the relationship between valuations of the husband role and stress reactions. If they are included, the relationship remains but is less marked.


21. ibid., Chapter VII.


23. op. cit. Chap. 9.


28. There are two possible explanations of this. Firstly, hospital doctors may, as professionals, be more devoted to work than managers. Secondly, hospital doctors may represent a select group of men who are particularly committed to work, while doctors who are less strongly committed to work may enter general practice.

29. See Chapter I, note 42.


31. Defined by Scanzoni in terms of objective factors (occupational status, education and income) and subjective factors (alienation and anomie).

32. ibid. p. 21.


S.M. Greenfield: English Rustics in Black Skin, 1966


34. R. Angell: The Family Encounters the Depression, 1936.

E.W. Bakke: The Unemployed Man, 1934.

Chapter VIII: The Marital Partnership

1. However, wives' accounts of the consequences of heavy workloads suggest that severe problems result from deprivation of assistance in household management, paternal deprivation and limited social activity. This is at odds with the finding that doctors' participation in these areas is not in fact substantially less than dentists'. It is probable that heavy workloads may have a not easily quantifiable effect in terms of generalised and continuing emotional support of wives in household management and child care. If this is so, then there is here an effect on the conjugal relationships which is not revealed by the amount of time actually spent by doctors in these areas of family life.

2. Wives were presented with the following response categories: everything, most things, some things, a few things, nothing.

3. Husbands were asked: 'How interested would you say you are in what your wife does with her day? Would you say you are interested in everything she does, most things, some things, a few things, nothing?'

4. This item is given a maximum score of 1 because it is not, like the other items, scaled to show the extent to which spouses turn to each other when bored, worried or depressed. Further, though the percentage of respondents spontaneously naming their spouses as therapy agents was small, most respondents, if asked directly, acknowledged turning to their spouses when distressed.

5. Evidence of this set of beliefs was produced in chapter VI.

6. See chapter IV.

7. My findings regarding the role hospital doctors and their wives are expected to play in relation to their husbands' careers parallel the findings of J.M. & R.E. Pahl (Managers and Their Wives, 1971, chapter 3) and of M. Young and P. Willmott (The Symmetrical Family, 1973 chapter 3).

8. See chapter IV. The giving of sympathy and encouragement over work concerns is really an aspect of the more general giving of emotional support which is usually regarded as a dimension of the marital partnership.

9. Respondents were asked: 'Would you say that your wife is/you are as helpful as she/you could be?'

10. Most responses fall into the same, few categories. Respondents comments indicate the pitfalls which bedevil attempts at quantification. It was apparent, for example, that a husband who said that he told his wife about most things could mean either that he told her about most of the things which happened during the day or that he told her about most of the things which he
Notes to Chapter VIII.

10. Cont.
regarded as important. The universe of the day's events
is different in each case so that what constitutes most things
for one man may constitute only a few things for another man.
The analyst is thus in the unhappy position of having to accept
at face value responses of doubtful validity or jettison his data.

11. Dentists are somewhat more likely than hospital doctors to talk
about the day's events and their work problems. This may have
been either because they have more time in which to do so or
because they felt greater need of wifely sympathy. On the
other hand, doctors are more likely to seek their wives' advice
about job changes. This may be because job changes are associated
with the intricate personal relationships of career climb rather
than with the financial details of partnership arrangements,
and/or because job changes are more likely to have repercussions
for the family. Wives were therefore more likely to be seen as
equipped to proffer advice and/or to be involved in the outcome.
in any case they changed jobs more frequently than dentists.

12. Cp Caplow's suggestion that the increasing diversification and
specialisation of occupational roles pose barriers to
Doctors feel that specialisation makes communication difficult
not only with wives (despite their medical background) but also
with colleagues in different specialties.


14. The actual question asked was: 'How interested would you say
you are in what your husband does at work? Would you say you
are interested in everything he does, most things, somethings,
a few things, nothing?'

15. I am referring here particularly to the early child-rearing
stage of the family life-cycle. The isolation of wives during
this period of the life-cycle is described by Gavron (H. Gavron:
The Captive Wife, 1966)

16. P.L. Berger & H. Kellner: Marriage and the Construction of
Reality: an exercise in the Microsociology of Knowledge in

17. Ibid. p. 23.

18. Ibid. p. 27.

19. The Pahls' study of managers and their wives (J.M. & R.E. Pahl:
Managers and Their Wives, 1971) and Young and Willmott's study
(M. Young and P. Willmott: The Symmetrical Family, 1973)
provide evidence of this.
APPENDIX I

HUSBAND'S QUESTIONNAIRE

Interviewee:
Interview date:

Address:

Occupation:
Occupational position:

BACKGROUND DATA

1. Date of birth:
2. Date of medical/graduation:
3. Date of Marriage:
4. I would like to know the places in which you lived between birth and getting married and the activity you were engaged in while you were in each place, with approximate dates.

<table>
<thead>
<tr>
<th>Place</th>
<th>Activity</th>
<th>Dates</th>
</tr>
</thead>
</table>

And what are the places you have lived in since getting married?

5. Parents * Marital status F's occupation 15 mins Edin Lothians Elswhere

Both alive
F dead/M alive
F alive/M dead
Both dead

* D = divorced
FR = F remarried
MR = M remarried
W = widowed
6. **Siblings**

<table>
<thead>
<tr>
<th>No of brothers: (step-brothers)</th>
<th>No of sisters: (step-sisters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>Occupational Status</td>
</tr>
<tr>
<td>Bs</td>
<td></td>
</tr>
<tr>
<td>Ss</td>
<td></td>
</tr>
</tbody>
</table>

* # of Husbands of sisters if married

7. **Children**

   How many children do you have?

   | Name | sex | age | school status |

**AIMS**

8. What I am particularly interested in is the different things different people aim at in life. Can we begin by talking generally about your main aims in life?

9. **If not always lived in Edinburgh**:  

   What considerations affected your decision to live in Edinburgh?

   b. What do you particularly like/dislike about living in Edinburgh?

C. Ideally where would you like to live?

Or: **If always lived in Edinburgh**

a. Have you ever considered moving from Edinburgh?

   Yes  No
b) If yes, where:
   reasons
   reasons for not moving
   If no, reasons for staying in Edinburgh

c) what do you particularly like/dislike about living in Edinburgh?

d) ideally, where would you like to live?

10. Could you describe the house you would like to have?

11. What led you to become a ... ?
   How did you come into ...... ?

12. Did you at any time want to be anything other than........ ?
   yes          no

13. What ambitions did your parents have for you as regards a career?

14. If you could start all over again, would you choose to be a........ or something else?
   same            something else
   If something else: what would you choose to be?

15. After qualifying/graduating what was your first job?

<table>
<thead>
<tr>
<th>Workplace</th>
<th>Position</th>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
</table>

16. To doctors:
Why did you choose the hospital service rather than some other branch of medicine?

To dentists:
Why did you choose general practice rather than some other branch of dentistry?

17. Ascertain by open-ended questioning:
(a) factors influencing choice of each job
(b) options open at each career point
(c) factors influencing decision to leave each job

18. What plans do you have for your future career?

19. All in all, would you say things had turned out v. well
  well
  about average
  badly
  v. badly

THE FAMILY AND WORK

20. In what, if any, ways has your work life been affected by family commitments?

21. In what ways if any has your family life, your wife's and the children, been affected by work commitments?

22. When you come home in the evenings do you tell your wife about things that happened at work?
   everything
   most things
   some things
   a few things
   nothing
23. When you have problems at work do you talk them over with your wife?
   all
   most
   some
   few
   none

24. If you are thinking about changing a job do you ask your wife's advice?
   yes  no

25. Would you say that your wife is sympathetic to how you feel about work?
   very sympathetic
   sympathetic
   fairly sympathetic
   not particularly sympathetic
   not at all sympathetic

26. a) In what if any ways do you think the wife of a hospital doctor/dentist could be most helpful to her Husband in his career?

   b) How important do you think this help to be?
      very important
      important
      fairly important
      not particularly important

27. Would you say that your wife is as helpful as she could be?

28. I am going to recount two hypothetical situations and I would like you to tell me what you think the man concerned should do.

   Mr. X has been offered a job which he really wants. But this job entails moving away to another town and his wife does not want to move away from her family and friends to a place in which she would know no one. What should he do?
29. Now let us consider the case of Mr A. Mr A has been offered a job which he really wants and which involves moving to another town. But his 7-year old son has been considerably upset by the number of moves he has already had to make. Mr A is advised that the child might be further upset if he is moved again. What do you think he should do?

30. I would like you to tell me what you think of this couple, John & Mary. They have been married for 7 years. They have two children. John who is very involved with his work brings work home most evenings & weekends. Mary complains that she is very much on her own. What do you think of this couple?

MARRIAGE

31. All in all would you say that in your marriage things had turned out:

   very well
   well
   about average
   badly
   very badly

32. Would you say that you are sympathetic to how your wife thinks and feels about things?

   everything
   most things
   some things
   a few things
   nothing
23. Would you say your wife is sympathetic to how you feel and think about things?
   - everything
   - most things
   - some things
   - a few things
   - nothing

24. How much of your innermost hopes & feelings do you tell your wife?
   - all
   - most
   - some
   - a few
   - none

25. When you are bored, worried or depressed what do you do about it?

26. Would you say that your wife contributes to your self-confidence:
   - to a very great extent
   - to a great extent
   - to some extent
   - a little
   - not at all

27. How interested would you say you are in what your wife does with her day? Would you say you are interested in:
   - everything she does
   - most things
   - some things
   - a few things
   - nothing
38. Could you please say what work means to you by indicating how important each of the following aspects of work is to you. Could you do so by ranking each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a good income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a position of authority &amp; responsibility which gives you the opportunity to make decisions</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a job people think well of</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>self-fulfilment - the opportunity to do a job which you feel you are really good at</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the opportunity to be of service to the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>security</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

39. Now could you say how important you think it is to your wife that work should offer you each of the following. Again could you please rank each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
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</tr>
<tr>
<td>security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
40. How important do you consider each of the following to be in a husband’s role? Could you please place each item on a scale from 1 - 5 where 1 = very important indeed & 5 = of little importance.

a) helping with chores & doing things about the house & garden 1 2 3 4 5

b) sharing with his wife responsibility for the children 1 2 3 4 5

c) giving his wife a comfortable & attractive home & a decent & secure standard of living 1 2 3 4 5

d) companionship – sharing leisure activities & interests with his wife 1 2 3 4 5

e) being sympathetic & understanding 1 2 3 4 5

41. Now could you please say how important you think your wife thinks each of the following to be in a husband’s role. Again would you please place each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) helping with chores & doing things about the house & garden 1 2 3 4 5

b) sharing with his wife responsibility for the children 1 2 3 4 5

c) giving his wife a comfortable & attractive home & a decent & secure standard of living 1 2 3 4 5

d) companionship: sharing leisure activities & interests with his wife 1 2 3 4 5

e) being sympathetic & understanding 1 2 3 4 5
42. Now I would like you to say how important you consider each of the following to be in a wife's role. Could you please do so by placing each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) making the home comfortable & keeping home life running smoothly 1 2 3 4 5

b) being good with the children 1 2 3 4 5

c) companionship: sharing leisure activities & interests with her husband 1 2 3 4 5

d) being sympathetic & understanding 1 2 3 4 5

e) being concerned that her husband should get what he wants out of work even if this means that he cannot be much involved in family life 1 2 3 4 5

43. Now could you say how important you think your wife considers each of the following to be in a wife's role. Again would you please place each item on a scale from 1 - 5 where 1 = very important indeed & 5 = of little importance.

a) making the home comfortable & keeping home life running smoothly 1 2 3 4 5

b) being good with the children 1 2 3 4 5

c) companionship: sharing leisure activities & interests with her husband 1 2 3 4 5

d) being sympathetic & understanding 1 2 3 4 5

e) being concerned that her husband should get what he wants out of work even if this means that he cannot be much involved in family life. 1 2 3 4 5
WIVES' QUESTIONNAIRE

Interviewee: 
Address: 
Occupation: 

BACKGROUND DATA

1. Date of birth: 
2. Date of Marriage 
3. I would like to know the places in which you lived between birth and getting married and the activity you were engaged in while you were in each place, with approximate dates.

<table>
<thead>
<tr>
<th>Place</th>
<th>Activity</th>
<th>Dates</th>
</tr>
</thead>
</table>

And after marriage:


Both alive
F dead/M alive
F alive/M dead
Both dead

D - divorced
FR - F remarried
MR - M Remarried
W - widowed
5. Siblings

<table>
<thead>
<tr>
<th>No of brothers:</th>
<th>No of sisters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(step-brothers)</td>
<td>(step-sisters)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Occupational Status</th>
<th>Where living</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Edinburgh, Lothians, Elsewhere</td>
</tr>
</tbody>
</table>

1)  

2)  

3)  

1)  

2)  

3)  

# of # of sisters if married

6. Children

How many children do you have?

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>School Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.  

2.  

3.  

7. Qualifications on finishing full-time education:

8. Occupation at marriage:

AIMS

9. What I am particularly interested in is the different things different people aim at in life. Can we begin by talking generally about your main aims in life?
10. a. What do you particularly like/dislike about living in Edinburgh?

c. Ideally, where would you like to live?

11. Could you describe the house you would like to have?

12. And you present house, what does it have?
13. In what ways, if any, has your family life, yours and the children's, been affected by your husband's work commitments?

14. Would you say that you are sympathetic to how your husband feels about work?

- very sympathetic
- sympathetic
- fairly sympathetic
- not particularly sympathetic
- not at all sympathetic

15. In what ways, if any, do you think the wife of a hospital doctor/dentist could be most helpful to her husband in his career?

b. How important do you think this help to be?

- very important
- important
- fairly important
- not particularly important

16. Would you say that you are as helpful as you could be?

17. How interested would you say you are in what your husband does at work? Would you say you are interested in everything he does?

- most things
- some things
- a few things
- nothing
18. I am going to recount two hypothetical situations & I would like you to tell me what you think the man concerned should do?

Mr X has been offered a job which he really wants. But this job entails moving away to another town & his wife does not want to move away from her family & friends to a place in which she would know no one. What should he do?

19. Now let us consider the case of Mr. A. Mr A has been offered a job which he really wants & which involves moving to another town. But his 7-year-old son has been considerably upset by the number of moves he has already had to make. Mr A is advised that the child might be further upset if he is moved again. What do you think he should do?

20. I would like you to tell me what you think of this couple, John & Mary. They have been married for 7 years. They have 2 children. John who is very involved with his work brings work home most evenings & weekends. Mary complains that she is very much on her own. What do you think of this couple?

MARRIAGE

21. In arranging... schooling, who had the most say in deciding which school... he should go to. (Ask for each child)

<table>
<thead>
<tr>
<th>Nursery School/ play group</th>
<th>Primary School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>H</td>
<td></td>
</tr>
<tr>
<td>W</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
</tr>
<tr>
<td>Circumstances</td>
<td></td>
</tr>
</tbody>
</table>
22. In arranging... schooling, who took the lead in making the necessary arrangements?

<table>
<thead>
<tr>
<th>Nursery School/Play Group</th>
<th>Primary School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>H</td>
<td></td>
</tr>
<tr>
<td>W</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
</tr>
</tbody>
</table>

23. About how often do you discuss how is getting on at school with his/her teachers?

<table>
<thead>
<tr>
<th>Nursery</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys  H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
<tr>
<td>W</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. Do you do your husband usually discipline the children?

<table>
<thead>
<tr>
<th>H</th>
<th>W</th>
<th>E</th>
</tr>
</thead>
</table>

25. Do you does your husband usually buy presents for the children?

<table>
<thead>
<tr>
<th>H</th>
<th>W</th>
<th>T</th>
<th>E</th>
</tr>
</thead>
</table>
26. When the children are troubled or unhappy to whom do they usually turn?

H
W
Either

27. Who does various household chores varies from family to family. In your family who usually:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) shops for groceries at weekends</td>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
<tr>
<td>b) washes/dries dishes after the evening meal</td>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
<tr>
<td>c) gets the children ready for bed</td>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
<tr>
<td>d) gets up in the night for the children</td>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
<tr>
<td>e) gets the children up &amp; dressed in the morning</td>
<td>H</td>
<td>W</td>
<td>B</td>
</tr>
</tbody>
</table>
f) puts out the buckets/bins

H
W
B
E

H
W
B
E

h) does minor household repairs/
painting/decorating

H
W
B
E

28. Who usually pays the monthly/
quarterly bills?

H
W
B
E

29. Who usually sends off Christmas
cards?

H
W
B
E

30. Do you get any help with
(a) the children or house-
work from

relatives

neighbours

wives of Hs colleagues

other friends

char/au pair
b) babysitting
relatives
neighbours
wives of H's colleagues
other friends
char/aun pair
relatives
neighbours
H's colleagues
other friends
other
c) garden

31. a. When you were buying/renting the house who took the lead in looking for it?

H
W
B

b. And who had the most say in deciding on the particular house you were going to buy?

H
W
B

32. a. When you are buying furniture/furnishings you takes the lead in looking for them?

H
W
B

b. And who has the most say in deciding on what you are going to buy?

H
W
B
23. When you were buying your last car
   a. who took the lead in choosing & buying it?
      H
      W
      B
   b. And who had the most say in deciding that a car should be bought at that time?
      H
      W
      B

24. When you are planning a holiday
   a. who usually makes the necessary arrangements?
      H
      W
      B
   b. And who usually has the most say in deciding where you should spend your holiday?
      H
      W
      B

25. When your husband comes home in the evening do you tell him about the things you did during the day?
    everything
    most things
    some things
    a few things
    nothing
36. All in all would you say that in your marriage things had turned out:

very well
well
about average
badly
very badly

37. Would you say that you are sympathetic to how your husband thinks and feels about things?

everything
most things
some things
a few things
nothing

38. Would you say that your husband is sympathetic to how you feel and think about things?

everything
most things
some things
a few things
nothing

39. How much of your innermost hopes and feelings do you tell your husband?

all
most
some
a few
none

40. When you are bored worried or depressed what do you do about it?

41. Would you say that your husband contributes to your self-confidence?

to a very great extent
to a great extent
to some extent
a little
not at all
42. Would you please say what you would like your husband's job to offer him by indicating how important each of the following aspects of his job is to you. Would you please do so by placing each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

- A good income: 1 2 3 4 5
- A position of authority & responsibility which gives him the opportunity to make decisions: 1 2 3 4 5
- A job which people think well of: 1 2 3 4 5
- Self-fulfilment - the opportunity to do a job which he feels he is really good at: 1 2 3 4 5
- The opportunity to be of service to the community: 1 2 3 4 5
- Security: 1 2 3 4 5

43. Now would you please say how important you think each of these aspects of work is to your husband. Again could you please do so by placing each item on a scale from 1 - 5 where 1 = very important indeed & 5 = of little importance.

- A good income: 1 2 3 4 5
- A position of authority and responsibility in which he has the opportunity to make decisions: 1 2 3 4 5
- A job people think well of: 1 2 3 4 5
- Self-fulfilment - the opportunity to do a job which he feels he is really good at: 1 2 3 4 5
- The opportunity to be of service to the community: 1 2 3 4 5
- Security: 1 2 3 4 5
44. Now I would like you to say how important you consider each of the following to be in a wife's role. Could you please do so by placing each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) making the home comfortable & keeping home life running smoothly

b) being good with the children

c) companionship: sharing leisure activities and interests with her husband

d) being sympathetic & understanding

e) being concerned that her husband should get what he wants out of work even if this means that he cannot be much involved in family life.

45. Now could you say how important you think your husband considers each of the following to be in a wife's role. Again would you please place each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) making the home comfortable & keeping home life running smoothly

b) being good with the children

c) companionship: sharing leisure activities and interests with her husband

d) being sympathetic & understanding

e) being concerned that her husband should get what he wants out of work even if this means that he cannot be much involved in family life.
46. How important do you consider each of the following to be in a husband’s role? Could you please place each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) helping with the chores and doing things about the house and garden 1 2 3 4 5

b) sharing with his wife responsibility for the children 1 2 3 4 5

c) giving his wife a comfortable and attractive home and a decent and secure standard of living 1 2 3 4 5

d) companionship - sharing leisure activities and interests with his wife 1 2 3 4 5

e) being sympathetic and understanding 1 2 3 4 5

47. How could you please say how important you think your husband thinks each of the following to be in a husband’s role. Again would you please place each item on a scale from 1 - 5 where 1 = very important indeed and 5 = of little importance.

a) helping with chores and doing things about the house and garden 1 2 3 4 5

b) sharing with his wife responsibility for the children 1 2 3 4 5

c) giving his wife a comfortable and attractive home and a decent and secure standard of living 1 2 3 4 5

d) companionship - sharing leisure activities and interests with his wife 1 2 3 4 5

e) being sympathetic and understanding 1 2 3 4 5.
# HUSBANDS' DIARY

## Activity

### Morning
- helping get the children up and dressed
- helping get breakfast
- having breakfast
- helping clear up after breakfast
- other (please specify what)

### Day
- time left for work
- lunch
- time left work
- called at pub/elsewhere (please say where) on way from work
- time arrived home

### Evening:
- helping prepare/clear up after evening meal

### Home activities
- having evening meal
- playing with children (please say what you were doing)
- helping get children ready for bed
- gardening
- doing things about the house (e.g. minor repairs/painting, etc.)
- watching TV
- listening to music
- reading
- talking with wife
- too exhausted to do anything
- other (please say what)
<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>with*</th>
</tr>
</thead>
<tbody>
<tr>
<td>working at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>working at hospital/office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reading work-associated literature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attending lectures/meetings in any way connected with work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>entertaining friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visiting friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at theatre/cinema/concert or in other cultural activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>playing a sport (please say what)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having dinner in a restaurant/at a party or dance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>taking part in a political, church, civic or social welfare activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other (please say what)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Please say whether you were doing each activity with:

1. your wife
2. your children
3. neighbours
4. colleagues
5. other friends.

Please classify as colleagues all fellow doctors/dentists (whether you are currently working with them or not) and regardless of whether you regard them as 'friends' rather than 'colleagues'.

* Please include casual dropping in for coffee, tea, drinks or just a chat.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Time from</th>
<th>to</th>
<th>with</th>
</tr>
</thead>
<tbody>
<tr>
<td>time got up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>helping prepare meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>having meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clearing up after meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attending to children (please say doing what)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>playing with children/taking children out (please say what/where)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>working at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>working at hospital/office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reading work-associated literature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attending meetings, lectures, conferences in any way connected with work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gardening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>doing things about the house (e.g. minor repairs/decorating)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>watching TV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>listening to music</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talking with wife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>too exhausted to do anything</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other home activity or hobby (please say what)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Time from</td>
<td>to</td>
<td>with*</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>entertaining friends +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>visiting friends +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at theatre/cinema/concert or in other cultural activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>playing a sport (please say what)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>having dinner in a restaurant/at a party or dance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>taking part in a political, church, civic or social welfare activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other (please say what)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Please say whether you were doing each activity with:

  - your wife
  - the children
  - neighbours
  - colleagues
  - or other friends

Please classify as colleagues all fellow doctors/dentists (whether you are currently working with them or not) and regardless of whether you regard them as 'friends' rather than 'colleagues'.

+ Please include casual dropping in for coffee, tea, drinks or just a chat.
**WIVES' DIARY**

<table>
<thead>
<tr>
<th>Weekday:</th>
<th>Day of Week:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time from</th>
<th>to</th>
<th>with</th>
</tr>
</thead>
</table>

**Morning**
- getting children up & dressed
- getting breakfast
- having breakfast
- clearing up after breakfast
- other (please say what)

**Day**
- taking children to school
- fetching children from school
- attending to children
- amusing children at home
- ironing/washing
- housework
- shopping
- visiting
- entertaining visitors
- getting lunch
- having lunch
- clearing up after lunch
- other (please say what)

**Evening**
- preparing evening meal

**Home activities**
- having evening meal
- clearing up after evening meal
- playing with/amusing children
- getting children ready for bed
- housework/ironing/washing
| Activity                                                      | Time from to | with *
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>knitting/sewing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gardening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>home-decorating/minor repairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>watching TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>listening to music</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>talking with husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other home activity or hobby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>too exhausted to do anything</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social

| Activity                                                      | Time from to | with *
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>entertaining friends*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visiting friends*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at theatre/cinema/concert or other cultural activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please say which)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>playing a sport (please say what)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having dinner in a restaurant/at a party or a dance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>taking part in a political, church, civic or social welfare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>activity (please say which)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other (please say what)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please say whether you were doing each activity with:
your husband
the children
neighbours
colleagues of your husband or their wives
other friends
or alone

Please classify as colleagues of your husband all fellow doctors/dentists
(whether he is currently working with them or not) and regardless of
whether you regard them as friends rather than as colleagues of your
husband.

*Please include casual dropping in for coffee, tea, drinks or just a chat.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Time from</th>
<th>to</th>
<th>with</th>
</tr>
</thead>
<tbody>
<tr>
<td>time got up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preparing meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>having meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clearing up after meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>housework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ironing/washing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>shopping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other domestic tasks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attending to children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amusing children at home (please say what doing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>on outing with children (please say where)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gardening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>home-decorating/repairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>watching TV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>listening to music</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talking with husband</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other home activity or hobby (please say what)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>too exhausted to do anything</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please say whether you were doing each activity with:

- your husband
- the children
- neighbours
- colleagues of your husband or their wives
- other friends

Please classify as colleagues of your husband all fellow doctors/dentists (whether he is currently working with them or not) regardless of whether or not you regard them as friends rather than as colleagues of your husband.

+ Please include casual dropping in for coffee, tea, drinks or just a chat.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time from to</th>
<th>with *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>entertaining friends*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visiting friends*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at theatre/cinema/concert or in other cultural activity</td>
<td></td>
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</tr>
<tr>
<td>playing a sport (please say what)</td>
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<tr>
<td>having dinner in a restaurant/at a party or dance</td>
<td></td>
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<tr>
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BIBLIOGRAPHY


BAKKE, E.W.: The Unemployed Man, Dutton, 1934.


BRITISH MEDICAL ASSOCIATION: Memorandum of Evidence to the Review Body on Doctors' and Dentists' Remuneration, March 1972.


EASTON, I.D.: Review of Hospital Junior Medical Staff in the Eastern Region of Scotland 1968/9, Eastern Regional Hospital Board, Scotland, 1970.


Ministry of Health/Scottish Home and Health Department : Minimum off-duty Time for Junior and Intermediate Grades of Hospital Medical and Dental Staff, HM(67)26 and SHM 30/67.

Ministry of Health/Scottish Home and Health Department : Professional and Study Leave for Medical and Dental Staff in the Hospital Service, HM(67)27 and SHM 41/68.


REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION:
Third, Fourth and Fifth Reports, Cmnd. 2535, HMSO, 1965.


SOUTH-EASTERN REGIONAL HOSPITAL BOARD: Junior Hospital Medical Staff Survey 1968-69.


SHELVED WITH THESIS BUT NOT PART OF IT.
OCCUPATIONAL COMMITMENTS AND PATERNAL DEPRIVATION

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Summary  In the post-war era the husband-father role has been enlarged to encompass active participation in family life. However, occupational commitments may inhibit active involvement in family life, particularly in the middle classes where work has traditionally been defined as salient. This article reports on an investigation of the consequences of heavy work commitments for father role performance and child development. This investigation, using the case study method, focussed on hospital medicine and the early child-rearing stage of the family life cycle. It was found that fathers felt themselves to be shadowy figures in the background of their children's lives and that mothers experienced single-handed responsibility for child-rearing as burdensome. Children have little experience of a father's companionship, and discipline and work pressures may be transmitted to them. A few children exhibited behaviour difficulties. Suggestions for further study are made.

INTRODUCTION
The family in modern Western societies has, as a result of the emergence of a particular constellation of marital and family values, been elevated to a position of supreme importance as a system of affective and security-providing relationships. In this ideology, family relationships are defined as meaningful and central for men as well as women and as critical to the needs and well-being of children. This definition of family living entails a significant change in the role of the husband-father. It implies that the husband-father role is no longer confined to breadwinning but has been enlarged to encompass active participation in family life. Thus the husband-father is expected to share with his wife responsibility for child-rearing and household management, to be a pal to his children and a friend to his wife.

A considerable body of evidence supports this view of the increasing
centrality of the family in the life interests of men. In the 1950s, for example, Young & Willmott (1957) observed, with some surprise, that modern young East End fathers wheel prams up Bethnal Green Road on Saturday mornings, take their daughters rowing and play with their sons on the putting green. They saw this as indicative of change in working-class family patterns.

A few years later Zweig (1961) reported similar changes in the lifestyle of affluent factory workers. 'Fathers of babies', he says approvingly, 'often push the pram, give them baths, see them to bed; fathers of toddlers often read them stories, play with them, take them for a walk at weekends; fathers of school children often go to the school for progress reports and supervise their homework; fathers of adolescents try to apprentice them or find them suitable jobs.'

Quantitative and perhaps more systematic evidence of paternal involvement comes from two longitudinal studies, the Newsons' Nottingham study (1963) and the National Children's Bureau National Child Development study (1976).

This change in the husband-father role is evidenced not only by sociological studies reporting his greater participation in family activity but also by various changes in our social arrangements. Perhaps the most dramatic of these are the arrangements hospitals now make for fathers to be present at the birth of their children.

Moreover, fatherlessness is not now dismissed, as it was by Bowlby (1951) for example, as unimportant to child-development. Research is now directed to the psychodynamic consequences of fatherlessness and a growing volume of evidence (which has been reviewed by Biller, 1971) suggests that fatherlessness may be associated with learning difficulties, emotional distress, delinquency and sex-role identity problems. As with maternal deprivation, the effects of fatherlessness seem to be mediated by the timing and duration of father-absence, the precipitating cause, the sex of the child and variations in socio-cultural arrangements and expectations.

One aspect of contemporary definitions of the husband-father role has, however, received relatively little attention. This is the potential for conflict between male familial roles and occupational roles. Expectations of active familial involvement presume the investment of time, energy and emotionality in family life. But the husband-father is also the chief breadwinner for the family and his occupational commitments may preclude this investment. There may thus be conflicts between the occupational role and the familial role—of the kind that have been long
recognised as existing for the working mother—and work-absorption may lead to paternal deprivations. This clearly represents a (largely unrecognised) social problem. The dimensions of the problem will vary with variations in occupational situations and values.

In manual occupations, the overtime work that may be necessary for providing the family with desired consumption patterns curtails the amount of time that the husband-father spends with his family, as Young & Willmott show in *The Symmetrical Family* (1973).

In various occupations the husband-father may be away from home for considerable periods. Tunstall’s work on Hull trawlermen (1962) and Tiller’s (1957, 1961) and Grönseth’s (1962) work on Norwegian seamen point to the implications of this kind of father-absence for wives and children. Both Tiller and Grönseth show that for much of the time the mother and children form a self-sufficient group exclusive of the father who is treated as a dear guest, a kind uncle, when he is at home. The mother becomes the main agent of socialisation and, Grönseth suggests, the father’s long absence tends to mean a markedly felt burden for mothers in terms of being alone with heavy responsibility for the children. Tiller suggests that father-absent children experience difficulty in making appropriate sex-role identifications.

However, it is in middle-class occupations that work is most likely to curtail familial involvement, for in these occupations work has traditionally been accorded priority. There are two reasons for this. Firstly, middle-class career structures, by holding out the prospect of continuous and predictable rewards, furnish a rationale for life (Weiss & Reisman 1963, Wilensky 1960, 1961). Work therefore tends to be important and valued. Further success in middle class occupations necessitates the expenditure of time and energy on the work task and in the assiduous cultivation of relationships with colleagues, clients and customers. This is so in large-scale bureaucratic organizations where success is achieved by promotion in a hierarchy of authority, responsibility and prestige and in competition with others. It is also true of the independent professions and of entrepreneurial activity, where success is achieved through expansion of the enterprise (Bell 1969). Secondly, within the highly developed sub-cultures traditionally associated with the older professions and with higher managerial occupations, work is defined as the area of life in which self-fulfilment is to be experienced. Devotion to the task—and therefore the expenditure of time and energy in work—is expected and the salience of the work role is assumed (Greenwood 1966, Hughes 1963).
Thus, in the middle classes, the husband-father is likely to be so work committed that both the amount of time he spends with the family and the significance of his family roles to his self-image may be limited. My exploratory study* of work-family conflict in hospital medicine throws light on the way in which father role performance and child development are affected.

This study was undertaken as a case study of the dilemmas middle-class couples are likely to experience as a result of the incompatibility of traditional middle-class work commitments with contemporary family values. Hospital doctors were selected as likely to exemplify this conflict for two reasons. Firstly, the medical sub-culture is particularly well developed and indeed has often been seen as the exemplar of the professional ethos. Secondly, various organisational constraints—the fact that patients must receive round-the-clock attention, the requirements of training for specialist status and the exigencies of career climb are known to contribute to heavy workloads.

The fieldwork was conducted in the Edinburgh area. The sample (38 hospital doctors and their wives**) was drawn from the registrar and senior registrar grades and consisted of married men of British origin, aged 38 or under, who had at least one child and whose wives were not currently in employment. The ages of the children ranged between a few months and 8 years. The study thus focussed on a particular stage of the family life-cycle. Thirty-four per cent of the couples had one child, 36% had two children and 29% had three or four children. Data was gathered by means of intensive interviews conducted separately with husbands and wives.

Nearly all the hospital doctors in the sample experienced heavy workloads. During a week for which they were asked to keep a diary of activities, 82% of the sample worked for more than 50 hours. Correlatively, they spent little time in familial activities.

The implications for father role performance were analysed in terms of (a) the hospital doctor's feelings about limited father-child involvement, (b) implications for the wife-mother and (c) effects on the children as perceived by the mother. Exploring the consequences for children in terms of mothers' perceptions of these consequences is methodologically problematic in that mothers may misconstrue the situation. However, the questioning of very young children on so complex an issue is difficult and direct observation is impracticable.

** The small size of the sample was necessitated by the exigencies of a one person research project.
Mothers' accounts do at least give us their perceptions of the effects of work-absorption on a child and are important insofar as their perceptions of what is happening can be expected to influence the child's reactions.

HOSPITAL DOCTORS' FEELINGS ABOUT LIMITED FATHER-CHILD INVOLVEMENT

Forty-two per cent of the men in the sample felt that their heavy workloads limited their relationships with their children. They felt themselves to be shadows in the background of their children's lives, to be missing out on the pleasure of seeing their children grow up. Fathers of very young children were disturbed because their children seemed scarcely to recognise them; fathers of older children because they felt themselves to be makers of vague and unkept promises, remote figures locked in a study to whose irregular comings and goings it was difficult for children to acclimatize.

The feelings of fathers may perhaps best be demonstrated by quoting from two of the interview schedules.

I would have liked to take the boys sledding in the last fall of snow. I'm always making promises that one day we will do... I never get round to it. I would like to have a specific family outing every Sunday so that the boys don't find me full of vague promises. They are well aware that they mustn't shout and play games when Daddy is reading.

(Father of three boys, aged 4½, 2½ and 9 months.)

... used to come and knock on the door. 'You come for a walk Daddy.' 'You come with us Daddy.' 'No, I've got lessons to do.' He used to keep on at me to teach him to swim and to do all sorts of things and he couldn't understand why he couldn't come and speak to me when I was working in the next room. He would come and knock on the door and... (his wife) would give him hell for disturbing me.

(Father of a boy aged 3 speaking of the time when he was studying for his Fellowship examinations.)

Yet most men, though regretting their limited child-involvement, accepted it as the inevitable concomitant of a work role which they believed must assume priority. As one man put it: 'Work is paramount. I often find myself in a situation where there is a conflict of interest between work and home—but frankly if I say “I'll be home for my son’s fourth birthday party” and an ill baby comes in you have no option really. The job comes first.' But there were others who were less sure that work should assume priority. These men were caught in a
conflict between work and family and tended to resent the hospital system as making unjustified demands on their time and energy. In the words of one doctor, 'I simply resent the system that requires me to devote time to study I would rather spend with the family'.

Implications for the wife-mother role

For the wives of hospital doctors, heavy workloads mean bearing the major responsibility of child-rearing and household-management. Wives carry the brunt of child care and interrupted nights and cope unaided with many of the household tasks traditionally associated with the husband-father role as well as with tasks traditionally associated with the wife-mother role.

Forty-two per cent of the wives in my study found being solely responsible for child rearing and household management a heavy burden. For many it was quite simply extremely exhausting, particularly during crisis situations such as illness or the arrival of a new baby. For some it was also frightening. Some wives, for example, found their husbands' absence at nights, when help from other sources was not readily available, nerve-wracking.

Extracts from two of the interview schedules illustrate the difficulties experienced by mothers.

'He went away at 7.45 in the morning and came home after the children were in bed. And he had to live in the hospital every third weekend and every third night. I felt it was terrible. I felt that I was bringing up the children all by myself. I was alone all day and to have the children all day is a bit much. It is far easier to cope with them when someone else is around some of the time.

(Mother of two children, married for 3 years, speaking of a period 6 months before the interview when her husband was in a particularly demanding job.)

'Just after we bought this house and ... was born, ... went off to London leaving me with a new house, a toddler and a baby to cope with. I coped quite well I think but I was periodically depressed. For example when ... had measles and I thought he was terribly ill and my mother-in-law arrived—she is not a capable person emotionally—she flaps and panics. I have periodic flashes of "I can't cope" said more to myself than anyone else. I never went to my G.P. but I have often wished that someone would take over from me, especially when we had the plasterers in doing maintenance and making an awful mess.'

(Mother of three boys, married for 8 years.)

The burden of single-handed child care was experienced in the context of an intense loneliness, since work-absorption deprived wives not only of practical assistance but also of companionship and emo-
Occupational commitments and paternal deprivation

Tional support. Seventy-one per cent of wives in the sample experienced loneliness. They found that opportunities for shared leisure activities both in the home and outside the home were restricted. They also found that opportunities for solo leisure activities outside the home were restricted since husbands could not always be relied upon for babysitting. As a result many evenings were spent alone at home watching television, reading, sewing, knitting or doing the ironing while husbands were on duty, preparing for examinations or keeping up with work-related literature. 'You become part of the furniture, you know,' one wife told me.

In this situation, few hospital doctors' wives can turn to their families of origin or to a close-knit community for help and emotional support. Geographical mobility is necessary to career climb in hospital medicine—as in many other large-scale bureaucratic occupational milieux. Consequently, the hospital doctor and his wife are usually separated from their families of origin and therefore from the practical help, moral support and friendship that might otherwise be given them by mothers and other relatives. Further, their constant mobility, in conjunction with the mobility of other professional people, tends to mean that their lives are lived out in the context of loose-knit and constantly changing networks which rarely provide the close relationships through which assistance in child care or day-to-day companionship may be found. The hospital doctor's wife is thus deprived both of her husband's involvement in family life and of close kin and neighbourhood ties.

The consequences for children

Forty-five per cent of the hospital doctors' wives in the sample believed their children to be affected by their husband's absorption in work. They felt that their children were growing up in a too-female environment and that this resulted in over-dependence on the mother. Children, they felt, need paternal discipline when their own attempts at discipline became 'just mother going on again'. They felt, too, that children (boys in particular) need their fathers' companionship—that fathers should play with them, take them to the zoo, go swimming with them.

The following extract from the interview schedules is illustrative of the way in which mothers felt that children were affected.

'The children do miss their father if he is not here at home for a bit. If he isn't around at bedtime, they get cheesed off. They complain when Daddy is not at
home at weekends when everyone else's Daddy is. They talk of the hospital as a nasty, black place.'
(Mother of two boys, aged 6 and 4.)

'The children don't understand that he has to work. Sunday mornings are worst because they think that when Daddy's home he is there to be played with. They make endless excuses to go into his study.'
(Mother of two girls, aged 5 and 3.)

Some mothers were disturbed by the way in which work pressures were transmitted to children. It is, they said, difficult for children when their father comes home tired, preoccupied, tense and unresponsive to, even exasperated by, their desire for attention and interest in their activities. 'The best you can do really,' one mother said, 'is to try to keep them in the picture and let them know why the pressure is on.'

Five mothers believed their children were exhibiting behaviour difficulties as a result of limited paternal involvement. The wife of an obstetrician and gynaecologist felt that her 3½-year-old son had become a hanger-on-of-apron strings in the absence of an adult male model. The wife of another obstetrician described her two children as fearful of men and said they could not be left in their father's care because he was so much a stranger to them. A third wife reported aggressive behaviour, a fourth sleep problems and a fifth schooling difficulties.

Some of these mothers may have been mistaken in attributing their children's behaviour problems to paternal work-absorption. But, even if this is so, a mother's account of the effects of paternal work-absorption will almost certainly be transmitted to her child to become an element in his image of his father and in his relationship to him.

The mother's misattribution of a child's behaviour problems may be a function of the frustration she herself feels, a frustration that leads her to interpret her child's behaviour problems as the result of paternal work-absorption when its cause lies elsewhere. But even where a mother is correct in thinking that there is a link between her child's behaviour problems and paternal work-absorption, the child's reaction may be a response to the atmosphere of tension and stress created by her frustration rather than to paternal deprivation per se. In other words, a child may be affected not simply by his own experience of paternal deprivation but by his mother's reaction to her husband's work-absorption and by the way in which she presents it to him. My own evidence is slight but Tiller's study (1957) also points in this direction.

Moreover the child's (apparent) reaction may be used by the mother as a means of bringing pressure to bear on the father so as to mitigate
her own frustrations. One case in my study may be cited in illustration of this. In this case the father as well as the mother attributed aggressive behaviour to work-absorption. But the husband added a rider to the effect that his wife used the child’s behaviour as a means of bringing pressure to bear on him when she was herself feeling frustrated by his work absorption. This may tend to happen where wives support the traditional professional ideology of total work commitment and therefore find it difficult to make claims on their husbands’ time on their own behalf.

However, my study also provided evidence that suggested that a wife’s resentment of her husband’s work absorption may sometimes stem from her perception of what it is doing to her child. The comment of one mother who said ‘I only mind when the children mind’ suggests this.

**DISCUSSION**

In sum, this study suggests that work commitments which absorb a father’s time, energy and emotionality constitute a type of paternal deprivation. It points to the deprivation experienced by the father himself, the frustrations experienced by the mother and the consequences for child development. The evidence—gathered in the context of a larger and exploratory study of work-family conflicts that focussed on a particular occupational group at a particular point in the family life-cycle—is limited but compelling and points to the need for further study. Three particular problem areas may be identified.

Firstly, the impact of work absorption is likely to be different in kind and intensity for boys and girls and at different stages of child development. Comparative and sex-differentiated studies of children at different stages of development are therefore needed.

Secondly, situations in which mothers are also working are likely to pose very different sets of values, choices and conflicts. Comparative studies of the implications of paternal work-absorption in dual career and single career families are therefore indicated.

Thirdly, long-term effects must be differentiated from short-term effects. In this context the model of the adult male role provided for the child by his father is of particular significance. The work-absorbed father represents one model, the family-absorbed father another. Each model—in conjunction with the approval or disapproval expressed by significant others—is likely to be of singular importance in shaping the
way in which boys will eventually play the husband-father role and the work role. Each is also of importance in shaping the expectations girls will come to have of their spouses.

This paper has argued that the problems consequent on work-absorption must be seen within the context of particular cultural definitions of the father role. It is suggested that it is within the context of expectations of the husband-father's active involvement in family life that his non-involvement is particularly likely to be productive of husband-wife tensions that may be transmitted to the child and to be consciously experienced as a deprivation by the child.

Finally it must be emphasised that attitudes towards work-absorption may make the paternal deprivation that it generates a different experience from paternal deprivation experienced in other circumstances. Hospitalization or death, for example, may simply be seen as the unavoidable dispensation of fate. Absorption in leisure pursuits may be resented as illegitimate. But work-involvement may be regarded as legitimate. As I showed at the outset, expectations of devotion to the task are embedded in middle-class cultures. Further work commitment, insofar as it is rewarded with increasing income and status, provides the family with material benefits and a life-style that may be highly valued and that may be impaired by a lowering of work commitments. It is precisely because of the legitimacy that may be attached to work that family-centred ideologies present painful dilemmas, conflicts and stresses.

REFERENCES

In Studies on the Family ed. Anderson N. Vandenhoek & Ruprecht, Göttingen
Tiller P.O. (1961) Father Separation and Adolescence. Institute for Social Research
mimeo., Oslo
Harcourt Brace, New York
Science Journal 12, 543
Kegan Paul, London
PROFESSIONAL AND FAMILY CONFLICTS IN HOSPITAL MEDICINE

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Abstract—In British hospital medicine work commitments have traditionally been strong. However, the heavy investment of time and energy in work by men is incompatible with the family values of modern Western societies which stress the importance of the active participation of the husband—father in family life. This article reports on a study that investigated the stresses consequent on the incompatibility of the contemporary family ethic with traditional work commitments by comparing hospital medicine with general dental practice. It was found that wives feel over-burdened by their almost single-handed responsibility for child-rearing and experienced intense loneliness. Three types of strategies for the management of work-family tensions were identified.

Work, the literature suggests, has traditionally played an important part in the life interests of the upper middle-class male—in structuring his identity, shaping his social relationships in and out of the workplace and providing him with intrinsic satisfactions. The middle classes, it is said, assume the salience of the work role. Devotion to the task and therefore the expenditure of time, energy and emotionality in work is expected [1]. This involvement in work derives in part from sub-cultural expectations of success [2], in part from the ideology traditionally associated with the older professions and with senior managerial occupations [3], and in part from the way in which middle-class career structures, by holding out the prospect of predictable and continuous rewards, furnish a rationale for life [4].

The priority traditionally accorded work in middle-class cultures left little scope for identification with familial roles and little time for involvement in family activities. It thus depended on the assumption of responsibility for household management and child-rearing by wives. This is clearly incompatible with the changing status of women and with the emergence of a family ideology in which marriage is defined as a partnership involving the sharing by husband and wife of household management and child-rearing, of leisure activities and friendships, and of emotional concerns [5]. This conception of marriage implies the salience of family roles for men as well as for women and the expenditure of time and energy in family activities by men as well as women.

In other words there appears to be a “lack of fit” between traditional middle-class commitments to work and the commitment to family roles and activities that stems from the changing status of women, and changing family values. The Pahl [6] and Young and Willmott [7] provide evidence of this conflict in senior management. My own study* of work—family conflicts in hospital medicine shows that hospital doctors and their wives experience similar dilemmas.

This study was undertaken as a case study of the dilemmas and stresses upper middle-class families may face as a result of the incompatibility of newly emergent family values with traditional professional commitments. Hospital doctors were selected as likely to exemplify this conflict for two reasons. Firstly, a highly developed and clearly articulated professional culture encourages identification with the work role and devotion to the task and gives rise to tightly knit colleague groups. Indeed medicine has often been seen as epitomising the professional culture. Secondly, the organisation of British hospital medicine leads to heavy workloads.

Workloads are shaped primarily by the need for round-the-clock patient care. This is provided by means of an on call system that involves working in the evenings and at weekends—i.e. in time normally regarded as non-work time. Further, the delivery of round-the-clock patient care tends to a long working week. This may be exacerbated by such factors as position in the hospital hierarchy [8] the differing emergency quotient of different specialties [9] and staffing shortages.

Workloads are weighted still further by the career commitments inherent in the organisational structure of hospital medicine. In hospital medicine, as in all hierarchical organisations, success is defined in terms of promotion up a career ladder and is therefore linked to a willingness to expend time and energy in career climb and to assume greater responsibility. Careers in hospital medicine are further structured by the tradition of consultant responsibility. Under this system full clinical responsibility and independence is accorded only to consultants. The sub-consultant grades are regarded as training grades. Succession to a consultancy is therefore the only mark of successful completion of a lengthy apprenticeship. Further, only consultant status brings security of tenure—in the training grades tenure is for a limited period.

This career structure shapes workloads in two ways. Firstly, in the early career stages workloads consist not only of patient care but also of the work involved in training for a specialism. Specifically, specialist status is attained by passing qualifying examinations for membership of the Royal College of the chosen specialism. This entails continuous study over a period of 1–3 years. Despite the provi-

sions that are now made for study leave, much of this work must be done in the evenings and at weekends. Secondly, a career in hospital medicine necessarily involves the pursuit of success (in terms of the attainment of consultant status). The young doctor is inevitably involved in a competitive struggle for a series of appropriate training posts and for a consultant post [10]. Success in this struggle is facilitated by extra-curricular effort in research and publication and in the cultivation of relationships with colleagues and seniors.

As it seemed desirable to have a foil to hospital medicine, general dental practice was also studied. Dentistry was selected for this purpose since it seemed likely to be exempt from the pressures usually making for heavy work commitments in the middle classes. The dental subculture is ill-defined and the workplace, by virtue of its isolation, fails to provide meaningful primary relationships. Further, dentistry is often experienced as mechanical, repetitive and monotonous. Hence important factors in the development of traditional professional commitments to work are absent. Moreover, monetary success may be achieved without working long hours. Dentists, as independent practitioners, are not salaried but receive fees for their professional services and success is therefore dependent on expansion of the enterprise. However, in National Health Service dentistry fees are fixed at levels intended to ensure that a target average net income (recommended by the Review Body on Doctors' and Dentists' Remuneration and agreed by the profession and Health Departments) is reached in a standard number of hours. Individual dentists could of course seek to exceed the target income by working beyond the standard working week but in practice target incomes have been reached whilst reducing the number of hours worked through improvements in dental technology [11].

In selecting the samples, controls were introduced so as to homogenize the samples and eliminate factors which might shape familial roles but which were extraneous to the problem. The medical sample was drawn from the Registrar and Senior Registrar grades. The dental sample was drawn from men with 3-12 years work experience. The samples were further restricted to married men of British origin, aged 38 or under who had at least one child and whose wives were not currently in employment [12].

The study was thus planned as a case study of the potential for work–family conflict in particular occupational groups at a particular point in the career and family life-cycle. This strategy was adopted so that the work–family conflicts pertaining to a particular situation might be clearly identified [13].

Sample size was limited to 38 junior hospital doctors and 16 general dental practitioners and their wives. These small numbers were necessitated by the exigencies of a one-person research project.

The fieldwork was carried out in the Edinburgh area. Data were gathered by means of a diary of activities which respondents were asked to keep for a week and by means of loosely structured interviews, conducted separately with husbands and wives. The diary material was used for the quantification of the amount of time spent in work, family and leisure [14].

The interview schedule contained both open and closed questions. Open questions were used so as to elicit respondents’ own accounts of the implications of work–family tensions and to capture the intricacies and complexities of attitudes to work and marriage. Closed questions were used where simple factual information was required [15].

In this paper work–family conflicts are reported on in terms of: firstly, the relative amount of time spent in work and family; secondly, the family problems resulting from heavy workloads; thirdly, strategies for dealing with the conflicting demands of work and family.

**PARTICIPATION IN WORK, FAMILY AND NON-FAMILIAL LEISURE**

I began the investigation of the implications of work commitments for the family by attempting to establish the relative amount of time spent in work and family. This data serves as a quantitative background to the exploration of respondents’ accounts of workload impingements on family life.

The time involvement in work of junior hospital doctors and general dental practitioners is shown in Table 1 [16]. This table shows that the workload of junior hospital doctors is very heavy: 82% of the doctors in my sample worked for more than 50 hr during the week for which diaries were kept, while 88% of the dentists worked for 50 hr or less.

As a corollary of their heavier workloads, hospital doctors spent less time in family activity [17] than dentists. Only 18% of the doctors, compared with 50%, of the dentists, spent more than 35 hr in family activity (Table 2). They also spent less time in non-familial leisure [18] (Table 3).

This data simply demonstrates in quantitative terms the obvious fact that the more time a man spends in work the less time he has to spend in family life—that hospital doctors who, as a group, have heavy workloads spend relatively little time in family life compared with general dental practitioners who, as a group, have moderate workloads.

More interesting is the comparison of time spent in different areas of family activity. This shows that dentists as well as doctors spend little time in household management, child-rearing and social activity (Table 4)—that is heavy workloads seem to have little effect on participation in these activities. Perhaps this was to be expected. In most households with non-working wives the burden of child care and household management necessarily falls to the wife as the husband is out of the home for the greater part of the day, while social activities tend to be limited by babysitter problems and financial circumstances.

**Table 1. Total weekly workload of junior hospital doctors and general dental practitioners**

<table>
<thead>
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<th>No. of hours worked</th>
<th>Doctors</th>
<th>Dentists</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Up to 50 hours</td>
<td>18</td>
<td>88</td>
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<tr>
<td>51-70 hours</td>
<td>61/2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Over 70 hours</td>
<td>21/82</td>
<td>-</td>
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<tr>
<td>Total %</td>
<td>100</td>
<td>101</td>
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<tr>
<td>Total N</td>
<td>34*</td>
<td>16</td>
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* N = 34 since 4 respondents did not return diaries.
Table 2. Participation in family life by junior hospital doctors and general dental practitioners

<table>
<thead>
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<th>Doctors</th>
<th>Dentists</th>
<th>Percentage</th>
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<tr>
<td>20 hours &amp; less</td>
<td>35</td>
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<td>50%</td>
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<td>21–35 hours</td>
<td>47</td>
<td>31</td>
<td>65%</td>
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<td>over 35 hours</td>
<td>18</td>
<td>50</td>
<td>100%</td>
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<td>100</td>
<td>0%</td>
</tr>
<tr>
<td>Total N</td>
<td>34*</td>
<td>16</td>
<td>0%</td>
</tr>
</tbody>
</table>

* N = 34 since 4 respondents did not return diaries.

Workloads do, however, have a marked effect on home leisure (on time spent in watching television, listening to music, reading, talking with wives or indulging in other hobbies). Workloads are thus curtailing the only area of family life in which there is likely to be significant sharing. For if household management and child-rearing are necessarily largely undertaken by wives and social activities are limited by child-rearing constraints, feelings of mutuality can only be derived from evenings spent together in quiet relaxation, talking about the day’s activities, soothing each other’s anxieties over the things that have gone badly, or sharing the pleasure of the things that have gone well.

The possible effects of limited participation in home leisure on the marital partnership are suggested by differences between doctors’ and dentists’ wives in the extent to which they talk about family matters with their husbands and in the depth of their emotional bond with their husbands. The wives of junior hospital doctors are less likely than the wives of general dental practitioners to talk to their husbands about the events of the day (Table 5) or to use their husbands as a source of emotional support (Table 6).

I cannot say with certainty that these differences result from differences in time spent in home leisure by husbands but the evidence is suggestive.

REACTIONS TO HEAVY WORKLOADS

The foregoing analysis details in quantitative terms the limitations to a husband’s familial participation that necessarily accompany heavy workloads. But if we are to understand fully the implications of heavy workloads for marriage and family life, we must explore the way in which workload impingements are subjectively experienced by husbands and wives by examining their accounts of these impingements. When we do so, we find that heavy workloads are generally experienced by wives, but not by husbands, as problematic for family life.

Table 3. Participation in non-familial leisure by junior hospital doctors and general dental practitioners

<table>
<thead>
<tr>
<th>No. of hours spent in non-familial leisure activity</th>
<th>Doctors</th>
<th>Dentists</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 hours and less</td>
<td>76</td>
<td>50</td>
<td>50%</td>
</tr>
<tr>
<td>6 hours &amp; over</td>
<td>24</td>
<td>50</td>
<td>65%</td>
</tr>
<tr>
<td>Total %</td>
<td>100</td>
<td>100</td>
<td>0%</td>
</tr>
<tr>
<td>Total N</td>
<td>34*</td>
<td>16</td>
<td>0%</td>
</tr>
</tbody>
</table>

* N = 34 since 4 respondents did not return diaries.

In hospital medicine heavy workloads are perceived as problematic for four areas of family life: (1) household management; (2) social activity; (3) husband-wife companionship; and (4) child-rearing.

Limited participation by husbands in household management was reported as problematic by 42% of the hospital doctors’ wives, and restrictions on social activity by 55% of the wives and 26% of the husbands. The perception of heavy workloads as limiting a husband’s participation in household management and social activity is at first glance surprising, given that the hospital doctor’s participation in these areas is not in fact substantially less than the dentist’s. However, it would seem that the effect of heavy workloads as a subjective experience is not to be gauged simply by the objective effect (in terms of number of hours spent in family activity). Wives’ accounts illuminate this point for their accounts suggest that as a subjective experience work time-commitments deprive them of generalised moral support in ways that are not

Table 4. Differential participation by junior hospital doctors and general dental practitioners in different areas of family activity

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Dentists</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 hours</td>
<td>68</td>
<td>63</td>
<td>50%</td>
</tr>
<tr>
<td>6 hours and over</td>
<td>33</td>
<td>38</td>
<td>65%</td>
</tr>
<tr>
<td>Total %</td>
<td>101</td>
<td>101</td>
<td>0%</td>
</tr>
<tr>
<td>Total N</td>
<td>34</td>
<td>16</td>
<td>0%</td>
</tr>
</tbody>
</table>

N = 34 since 4 respondents did not return diaries.

Table 5. Extent to which wives of junior hospital doctors and general dental practitioners talk to their husbands about the day’s events

<table>
<thead>
<tr>
<th>Amount of communication</th>
<th>Doctors’ wives</th>
<th>Dentists’ wives</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talks about</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>everything/most things</td>
<td>47</td>
<td>75</td>
<td>50%</td>
</tr>
<tr>
<td>some things</td>
<td>32</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td>few things/nothing</td>
<td>18</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>unclassifiable response</td>
<td>3</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Total %</td>
<td>100</td>
<td>100</td>
<td>0%</td>
</tr>
<tr>
<td>Total N</td>
<td>38</td>
<td>16</td>
<td>0%</td>
</tr>
</tbody>
</table>

Wives were asked: when your husband comes home in the evening do you tell him about the things you did during the day? About everything, most things, some things, a few things, nothing.
easily quantifiable. It seems that where husbands are work-absorbed, some wives feel unaided and unsupported in child care and household management. They find this both exhausting and frightening, particularly in crises situations such as the arrival of a new baby, illness or house removal. Further, wives’ accounts suggest that number of hours worked is only one aspect of the workload situation affecting family life. Participation in household management and social activities may also be affected by irregularity of hours worked, an irregularity which disorganises household routines, producing non-existent teas and chaotic dinner parties, and which restricts social life by making it difficult to plan social activities in advance and by ruling out activities such as evening classes which demand a firm commitment to a particular day of the week.

Limitations on husband–wife interaction — the third problem area — were reported by 71% of hospital doctors’ wives. This was for wives the most stressful consequence of heavy workloads — as indicated by the intensity as well as the frequency of their accounts of loneliness.

Heavy workloads, and the concomitant restrictions on the familial involvement of husbands, leave non-working wives without meaningful adult company since there are for them no certain set of relationships outside the family in a mobile society. The resulting isolation was acutely distressing for many wives in the sample, particularly during periods of preparation for examinations, periods of husband-absence and at weekends.

During periods of preparation for examinations hospital doctors may spend the entire evening in their studies. They retire to their study after the evening meal and emerge only to go to bed. Their spouses sit in the living room, watching television, reading, sewing, knitting or doing the ironing. When there is no study and only one living room, television viewing is not ‘on’. “You become part of the furniture”, one wife told me, and others described this period as “ghastlier”, “a horrible time”, a “black patch”.

Periods when husbands were not much at home in the evenings either because they are frequently on call or are required to sleep in the hospital are experienced as even “ghastlier” than examination time by some wives. Studying husbands may not be companionable but their mere presence provides some solace. Absent husbands on the other hand make a complete vacuum of the evening, often depriving wives of the only human contact that can enliven a day spent within the four walls of a house in housework and child care, with little opportunity for talking to anyone other than the children, the butcher and, perhaps, for a few brief moments, the wife next door.

Husband-absence is also experienced as particularly trying at weekends when comparisons can all too readily be made with the position of neighbours. The visible image of conjugal companionship with which wives may be surrounded as neighbouring husbands wash the family car, tend their gardens or engage in family outings exacerbate feelings of loneliness, of injustice, and of resentment.

The loneliness that most hospital doctors’ wives experience as resulting from the curtailment of shared home leisure is experienced by only 16%, of hospital doctors. Their accounts suggest that the social relationships of work provide them with expressive satisfactions — that they do not have the same need for conjugal companionship that their wives have. This may also explain why they experience deprivation of social activity as problematic less often than their wives.

<table>
<thead>
<tr>
<th>Emotionality index</th>
<th>Doctors</th>
<th>Dentists</th>
<th>Doctors’ wives</th>
<th>Dentists’ wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores of 5 and less</td>
<td>31</td>
<td>19</td>
<td>83%</td>
<td>56%</td>
</tr>
<tr>
<td>Scores of 6–8</td>
<td>50</td>
<td>63</td>
<td>48%</td>
<td>38%</td>
</tr>
<tr>
<td>Scores of 9 and over</td>
<td>19</td>
<td>19</td>
<td>45%</td>
<td>63%</td>
</tr>
<tr>
<td>Total %</td>
<td>100</td>
<td>101</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>Total N</td>
<td>38</td>
<td>16</td>
<td>38</td>
<td>16</td>
</tr>
</tbody>
</table>

The emotionality index was calculated by scoring responses to the following questions as indicated.

Would you say that you are sympathetic to how your husband/wife thinks and feels about things? (response categories: everything—scored 3; most things—scored 2; some things—scored 1; a few things/nothing—scored 0).

Would you say that your wife/husband is sympathetic to how you feel and think about things? (response categories: everything—scored 3; most things—scored 2; some things—scored 1; a few things/nothing—scored 0).

How much of your innermost hopes and feelings do you tell your wife/husband? (response categories: All—scored 3; most—scored 2; some—scored 1; a few/none—scored 0).

When you are bored, worried or depressed, what do you do about it? (spontaneous naming of spouse as a therapy agent: scored 1).

Would you say that your wife/husband contributes to your self-confidence? (response categories: to a very great extent—scored 3; to a great extent—scored 2; to some extent—scored 1; a little/not at all—scored 0).

Scores for each item were summed, giving an emotionality index ranging between 0–13.

Table 6. Depth of the emotional bond between junior hospital doctors, general dental practitioners and their wives
In fact the only workload problem that hospital doctors spoke of with any frequency was the limitation of the father-child relationship. This was reported as problematic by 45% of hospital doctors. These men seemed to feel that they were missing out on the pleasures of seeing their children grow up and were becoming “shadowy” figures in the background of their lives. Fathers of very young children are disturbed because their children seem scarcely to recognise them, fathers of older children because they are full of vague promises which are never kept. Remote figures locked in a study who must not be disturbed and to whose irregular comings and goings children find it difficult to acclimatise.

45% of the wives also regarded limited father-child interaction as problematic. These wives seemed to be particularly concerned with the effects on children of growing up in a female environment. They feel that children, boys especially, need a father’s companionship and discipline, that a situation in which a wife is, as one wife put it, both mother and father to her children, results in over-dependence on the mother.

Five wives reported behaviour difficulties as resulting from this situation. The wife of an obstetrician and gynaecologist reported that their 3½-year-old son had been sent to a nursery school because he was becoming a hanger-on-to-of-apron-strings in the absence of an adult male model. The wife of an obstetrician reported that their children were afraid of men and could not be left in the care of their father because he was so much a stranger to them. A third wife reported aggressive behaviour, a fourth sleep problems and a fifth schooling difficulties.

Some of these mothers may have wrongly attributed their children’s behaviour problems to paternal work-absorption—perhaps as a result of their own discontents. But even if this is so, a mother’s account of the effects of paternal work-absorption will almost certainly be transmitted to the child to become an element in his relationship with his father.

When we turn to examining the workload problems of dentists and their wives, we find that their experiences are in marked contrast with those of hospital doctors and their wives. Workloads in dentistry are, as reported earlier, moderate. Further the accounts given by dentists and their wives of work time commitments suggest that they are not generally subject to those pressures which exacerbate the effect of the length of the working week in hospital medicine. Firstly, their working week, unlike that of the hospital doctor’s, is predictable. Secondly, absence from home overnight is not involved. Thirdly, by virtue of the control they exercise over their working situation, late appointments or Saturday morning appointments may be cancelled in the interests of familial activity. Finally, most dentists frequently go home for lunch; as a result children see their father at lunch time even when they do not see him in the evenings and the tedium and loneliness of the day is broken for wives. But despite the limited nature of workload impingements on family life in dentistry, a few dentists’ wives complained of late surgeries and of Saturday morning surgeries as limiting the amount of time that husband and wife and father and child could have together in the evenings and at weekends. That these complaints should be made at all, given the standard nature of the dentists’ working week, is indicative of the extent to which expectations of familial involvement may be productive of tension between work and family.

**STRATEGIES FOR MANAGING WORK-FAMILY TIME-DEMANDS**

The previous sections have shown that heavy workloads inhibit the hospital doctor’s involvement in family life and that this is experienced as problematic by most wives and by some husbands. In this section I examine the strategies husbands and wives adopt in dealing with work-family competition for time [19].

Three types of strategy are used: (1) accepting strategies; (2) evasive strategies; (3) militant strategies. The use of one strategy rather than another seems to be determined in part by the exigencies of the situation, but in part, also, by attitudes to the legitimacy of work/family demands. Spouses may use the same or different strategies. Moreover some respondents used more than one strategy, this seemingly representing ambivalent attitudes to the legitimacy of work-family time demands.

### Accepting strategies

Accepting strategies include the development of family rituals, the cultivation of alternative sources of help and companionship by wives and the curtailing of non-familial leisure by husbands.

Family rituals were developed by some couples so as to ensure that all the family are together at some time. For example, some couples set aside a particular time each day for the children—bath time and bedtime may also be time with father and the ordinary business of daily living is then transmitted by the spirit of family solidarity. To facilitate this, children may be kept up late. Conversely, some wives deal with the time when they must be on their own in a ritualised way. Typically, a ritual is made of demanding household chores or tasks such as hair-washing or letter-writing which are saved up for weekends or evenings when husbands are on duty so that there is something to absorb their energies at these times.

The development of alternative sources of companionship was a strategy adopted by some wives as a mean of alleviating loneliness. Some did so by developing outside interests such as evening classes, others by the assiduous cultivation of neighbourhood ties. Two wives said they were helped in maintaining contact with the outside world by having a car of their own. Alternative sources of help in household management and child care were also used. A few wives off-loaded domestic chores on to charladies and some used nursery schools as a means of providing their children with contact with adults other than themselves [20].

Mating selection may also be used as a conflict-resolving strategy. The choice of a mate who is likely to endorse career aspirations and accept the traditional segregated marital relationship clearly obviates work-family tensions. As one doctor put it, “You’ve got to select your wife carefully. Long before I married… I knew that she would be the right wife,
that the children could be left in her hands, that she
would be stable and sensible. I can think of chaps
who have been infatuated by pretty girls and the
results have been disastrous". At the same time the
decision to marry a hospital doctor had for some
wives constituted a decision to accept the life-style
that accompanies his occupational position. This may
be inferred from the fact that some wives said that
husband-absence had been expected.

Though mate-selection in the light of occupational
aspirations seems to have been consciously adopted
as a career-enabling strategy in only a few cases, car-
er commitments must nevertheless have had a con-
siderable, if unnoticed, effect on courtship. Work
commitments would have interfered with courtship
procedures as they interfered with marriage and it
is reasonable to suppose that many budding relation-
ships were blighted by a girl's unwillingness to
acquiesce in work-determined limitations to court-
ing [21]. In this context it is interesting to note that
58% of wives in the sample came from medical or
para-medical backgrounds; they thus came to mar-
riage with some knowledge of a hospital doctor's way
of life.

Accepting strategies are individual strategies, that
is strategies adopted by the hospital doctor and/or
his wife acting as individuals. Further, accepting stra-
tegies represent the adaptation of family life to heavy
workloads. Thus the dominance of such strategies in
the life style of one or other spouse or of a couple
suggests the legitimation of the heavy investment of
time in work by that spouse or by the couple. And
indeed it was clear that work was paramount for
some of the hospital doctors in my sample. This was
evident in such statements as "family commitments
have to be secondary"; "medicine is a way of life and
the rest of your life is adapted to it". Moreover some
of the wives in my sample also accepted the priority
of work. Some did so with fatalistic resignation—"It
can't be any different, so you learn to live with it",
one wife told me—but some seemed to do so gladly.

This acceptance of workload impingements on family
life seemed to exist within the context of a set of life interests in which the achievement of occu-
pational aspirations is seen as the principal source of
self-fulfilment for men and therefore as central to
their happiness. Believing this, many hospital doctors
and some wives argued that the achievement of occu-
pational aspirations is also necessary to family hap-
iness since occupational frustration would rebound
on the family. Therefore, it was argued, wives ought
to share their husbands' aspirations and accept, on the
one hand, work time investments, and, on the other
hand, sole responsibility for household management
and child-rearing, the restriction of their social life
and loneliness. In other words, the marital partner-
ship is here being defined in traditional terms as
revolving around, not the husband's participation in
family life, but wife's support of occupational aspira-
tions through the organisation of family life around
the exigencies of work. This accords with the tradi-
tional professional ideology of devotion to the task
and the priority of work.

Evasive strategies

Evasive strategies are aimed at the avoidance or
reduction of heavy workloads. My data suggests that
this may be done in two ways.

Attempts may be made to limit the time spent in
work by curtailing activities such as research and
publication which are necessary to the process of
carving out a career in hospital medicine but which
are not immediately essential to patient care. This
course of action represents an ordering of priorities
in the allocation of time, a compromise by which the
patient is given priority over the family but career
goals are circumscribed in the interests of the family.

Alternatively, career paths may be chosen so as to
maximise the opportunity for meeting family
demands. Thus five doctors entered specialties which
were believed to be relatively undemanding of time
and energy. These were either underpopulated spe-
cialties in which competition is less intense than in
crowded specialties, or specialties in which the emer-
gency quotient in patient care is low. As one respon-
dent put it, "One reason for choosing psychiatry was
that I didn't think I would have the stamina for other
degrees. If you've young kids, inevitably you don't
put in as much time on work as you would like to.
It's important to take them out for you feel guilty
if you don't."

These evasive strategies—like accepting strategies—are
individual strategies. And, like accepting stra-
tegies, they are not strategies that challenge the occu-
pational system. Rather, they represent the curbing of
occupational aspirations within given occupational
structures so that there may be time for familial in-
volveinent.

An alternative set of evasive strategies are available
to hospital doctors. These are strategies that evade
the problem of work—family competition for time not
by limiting career aspirations but by postponing mar-
rriage and/or child-bearing until the severe time
demands and uncertainties of the early stages of
career-building are over.

In the past hospital doctors—like other profes-
sional people—did in fact postpone marriage and
children until careers had been established. But there
was in the 1950s and 1960s a steady trend towards
earlier marriage among professional people [22]—a
trend that may have been symptomatic of the impor-
tance that was coming to be attached to marriage
as a system of affective relationships. This trend exa-
cerbated work—family conflicts by bringing career-
building and family-building into the same life-cycle
period.

My sample was, of course, drawn from a popula-
tion of married doctors with children and can there-
fore be presumed to be composed of men who had
not opted for family-evading strategies. Most of the
sample had in fact embraced family life at an early
age. 39% of these doctors had married before regis-
tration. 74% had not passed their Membership/Fel-
loreship examinations at the birth of their first child.
Whether the unmarried and childless men not in-
cluded in my sample were deliberately using family-
evading strategies is not known by virtue of the
research design.

Militant strategies

Militant strategies are, by contrast with accepting
and evasive strategies, collective strategies. They are
also radical strategies in that they represent a refusal to accept existing organisational structures and adapt personal goals thereto.

Recourse to militant action by junior hospital doctors reflects a deeply felt discontent with income levels, with the uncertainties of the hospital career structure and with workloads. It has been directed not only against employing authorities but also against other branches of the profession who were regarded as ignoring the needs of junior hospital doctors.

This discontent first found concrete expression in the formation of the Junior Hospital Doctors Association in 1966. In the late 1960s and early 1970s the J.H.D.A. acted as a catalyst in mobilising protest. It sought to win improvements in working conditions by mounting an active publicity campaign to draw attention to these conditions [23] and by seeking to secure stronger representation for junior hospital doctors either within the British Medical Association or independently of the B.M.A. so that their interests might be more forcefully articulated in the corridors of power [24]. The B.M.A. responded by granting its Hospital Junior Staff Group Council (now the Hospital Junior Staff Committee) autonomy within the B.M.A. framework and the right to negotiate directly with the Departments of Health on pay and conditions of work.

By stages and with the resort to trade union style tactics in 1975, junior hospital doctors secured the right to a contract on appointment specifying inter alia the rosters and on-call duty associated with the post, the right to pre-contract for payment of work in excess of a 40-hour week and recommended minimum off-duty time of 88 hours a week. It had been envisaged that payment for overtime work would result in a reduction of workloads by bringing about more efficient administration and the less profligate use of hospital doctor's time [25]. This has not yet happened. Nevertheless the concessions that have been won represent a considerable change from the situation that existed prior to 1967 when there were no assured periods of off-duty and salaries covered the total working week, however long it was.

The demand for a shorter working week and for payment for overtime working is a dramatic departure from the unquestioning acceptance of long working hours that once prevailed in hospital medicine. It runs counter to the traditional professional ethos which recognises no institutionalised clocking out time [26]. The trade union style tactics which doctors have sometimes employed also run counter to the traditions of the medical profession and many hospital doctors, particularly older hospital doctors, are deeply ambivalent about the use of such tactics [27].

Many factors are doubtless responsible for this change in traditional behaviour. It can in part be attributed to a perceived erosion of the rewards that hospital medicine used to offer once consultant status was attained [28]. But it may also stem from a desire for more non-working time, a desire that may in part be the outcome of the new family ethos and of the incompatibility of this ethos with the traditional medical ethos. This is speculative in that collective action gained momentum since my fieldwork was done. It may however be noted that parallel evidence of an association between the spread of the ideology of the partnership marriage and a questioning of traditional middle-class commitments to work has been found in senior management [29].

CONCLUSION

This study demonstrates the conflict that exists between work and family for the time of the hospital doctor and the strategies that may be adopted for the resolution of this conflict. The position of the hospital doctor was contrasted with that of the general dental practitioner who, working in a very different occupational situation and possessing an ill-articulated professional culture, is not confronted with this conflict situation.

The study was devised as a case study of the work-family tensions that are increasingly likely to arise as a result of the incompatibility of the commitments to work traditionally found in the older professions and in senior management with the changing status of women and with expectations of a partnership marriage. Such expectations, in fact, pose for men the same kind of conflicts and stresses that have long been recognised as existing for women who seek to combine a career with motherhood.

REFERENCES

8. Responsibility is delegated downwards from the consultant but the chain of referral is upwards from house officer to registrar and from registrar to consultant. This means that the brunt of emergency calls is borne


10. In many specialties the number of doctors in the sub-consultant grades is greater than the number for whom a consultant post is likely to be available. Consequently competition for advancement is intense.


12. For an account of the way in which the sample was selected, see Robertson F. Work and the conjugal family. Ph.D thesis. Edinburgh University, 1975.

13. Thus this study says very little about work–family tensions in the pre-child rearing stage of the family life cycle or among childless couples or where career peaks have been attained. Further, by restricting the sample to families in which wives were not currently working, little could be said about situations in which motherhood is combined with work, situations which almost certainly contain different sets of values, choices, tensions and tension-resolving strategies. These areas must be the subject of other and further study. The decision to limit the study to families in a particular stage of the life cycle was influenced by the need for a small sample—given the constraints of a one-person research project.

14. For a discussion of the problems of the diary method, see Robertson, op. cit.

15. This usage of open and closed questions is well established. See Oppenheim A. N. Questionnaire Design and Attitude Measurement. Heinemann, London, 1966.

16. Workloads include attendance at lectures and meetings, time spent in study, reading work-related literature, attending to correspondence at home and travel time. For doctors being on call from home was not treated as work unless the respondent was actually called out.

17. Familial activity includes participation in domestic tasks, interaction with children, social activities with elementary family members and home leisure.

18. Non-familial leisure refers to social activities with people other than elementary family members.

19. Since work–family conflicts in dentistry are minimal, this section is concerned with hospital medicine only.

20. Paid employment may sometimes be seen as a strategy for alleviating loneliness. Three wives planned to return to work for this reason when their children were older. Three wives said that they had returned to work for a short period in the past but had found the stress of combining motherhood with working intolerable. This is always a problem—as numerous studies of working mothers have shown. The particular demands of hospital medicine may, however, exacerbate the problem and if this is so poses particular dilemmas for the dual career family.

21. In other words, mate selection may involve a matching of role definitions—so that work-committed men and women who accept traditional definitions of familial roles are brought together. The sifting process is obviously not perfect, but to the extent that it works it helps to contain work–family tensions.


23. Inter alia, the JHDA produced its own publication “On Call”.

24. The interests of junior hospital doctors, like that of other groups of doctors, had traditionally been articulated by the B.M.A. But hospital doctors had come to feel that the B.M.A. was so structured that their interests were subordinated to those of G.P.s and hospital consultants. The retention fee issue was one expression of this feeling. Moreover many hospital doctors, and indeed other groups of doctors, were coming to feel that trade union style tactics would be more appropriate to modern circumstances. This was reflected in increasing recruitment to the Medical Practitioners Union (now affiliated with the Association of Scientific, Technical and Managerial Staffs) in the early 1970s (Gordon H. and Iliffe S. Pickets in White. MPU Publications. London 1977). Trade union style tactics were adopted by both junior doctors (over the pricing of “over time” working) and consultants (over the retention of private practice in the N.H.S.). Indeed the B.M.A. has even discussed affiliation with the T.U.C. (Gordon and Iliffe op. cit.).


27. Gordon and Iliffe, op. cit.

28. Ibid.