# The Psychology of Transference: Gender and Access to Training—the Mechanisms of Disadvantage

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Within nursing, career breaks have an impact on women’s career outcomes. However, the causal mechanisms that explain the transfer of women’s relative reduced career out- comes remain unclear. This article examines the relationships between career breaks, part-time working, and access to training/updating skills in determining nurses’ career outcomes. We consider this to be a mechanism of transferring disadvantage both within and between genders within nursing.

This qualitative research involved in-depth interviews with 32 registered female nurses with and without children. They were employed in “acute” nursing and worked as registered Band 4 to “senior nurse managers” and were between 25 and 60 years old. They worked or had worked under a variety of employment conditions. Some, but not all, had taken career breaks or requested or attained postregistration training.

We found that restricted access to training for part-time nurses and limited oppor- tunity to update their skills following a return from a career break are determining fac- tors affecting the career outcomes of nurses. The findings suggest that it is related to rationing of training for those returning from career breaks, based on the availability of a supply of newly qualified nurses meeting the numerical demand, financial constraints,

operational imperatives, and organizational values.

**Introduction**

Nursing is a female-dominated profession, with a female workforce of 89 to 90%, while 98.90% of nurses working part-time are female (Information Services Division [ISD], 2014). Within the nursing workforce, women who have not taken a career break, and men, regardless of whether they have taken a career break, have great- er career outcomes (McIntosh, McQuaid,

Munro, & Dabir-Alai, 2012). Women who take a career break are adversely affected, in part because having child care responsi- bilities limits their ability to enhance their human capital in one form or another (McIntosh et al., 2012). This in itself only partially explains women’s differential career outcomes. Restricted access to training after a career break and while working on a part- time basis is also a significant problem.

Within the processes of promotion and career

progression within nursing, suitability for promo- tion significantly weighs accredited academic and postregistration vocational qualifications (Robin- son & Griffiths, 2007). This is a critical arbiter in deciding career outcomes.

In this article, accessing and receiving train- ing among female part-time nurses and those returning to nursing after a career break will be examined. The rationale for receiving or being denied access to training will be examined along- side the operational and cultural circumstances in which this takes place. The next section outlines the main background literature, focusing first on human capital, career breaks, and part-time work- ing in nursing. The methods are then described and the findings presented. Finally, the results are discussed and conclusions drawn.

**Human Capital, Career Breaks, and Part-Time Working**

Human Capital, Qualifications, Training, and Nursing

In addition to formal qualifications and train- ing, other factors such as attitudes, competences, and experience are important in career develop- ment. Human capital is the stock of experience, skills, knowledge, competences, and attributes that a person embodies and that may provide a value to an employer (Agustin, 2007; Olsen & Walby, 2004). However, Hegarty and Golden (2008) have argued that there are other forms of “capital,” such as social, cultural, economic, and symbolic capital. As a surrogate measure of abil- ity to perform a job, employers often use indica- tors such as qualifications and years of experience to gauge the potential and worth of an employee. Higher qualifications are thought to demonstrate

(or at least suggest) higher potential performance

to employers and that the person has the ability to acquire knowledge and has gained potentially useful knowledge and skills (Spence, 2002). Paull (2008) links qualifications to career outcomes, so it is likely that career outcomes are partly linked to interrupted work histories.

It is possible to take a more explicit account of factors linked to gender. Employees with a greater number of years’ experience are seen to have acquired an *in-situ* skills development or education that is of value to an employer (Brown

& Jones, 2004; Hegney, Plank, & Parker, 2006). This factor was particularly noticeable in relation to the access and receipt of training. Broadbridge, Maxwell, and Ogden (2007) note that there may be higher cost implications (or reduced returns from the training) associated with women, since there is the possibility that they would take mater- nity breaks and so reduce their access to training. However, Rondeau, Williams, and Wager (2009) found that higher perceived human capital and the level of staff training of nurses in Canada were associated with lower establishment staff turnover and reduced overall costs. Prowse and Prowse (2008) found that changes in role redesign and the traditional emotional, social, and caring skills associated with a midwife are undermined by the growth in technical work. Concerns about the implications of work redesign, career breaks, part-time working, and professional boundaries reflect the uncertainty surrounding the profession (Hegarty & Pratto, 2004).

In nursing there is a strong relationship between knowledge, practical training, and qualifications. These relationships are reinforced by statute. Within the United Kingdom, legal safeguards regulate provision in relation to the access and availability of professional training for all nurses equally. The Nursing and Midwifery

Council (NMC) sets and reviews standards for

nursing education, training, conduct, and perfor- mance. Training operates within the framework of equal opportunities legislation and policies (ISD,

2014). Robinson and Griffiths (2007) noted that perceptions concerning competency were directly related to the acquisition of “accepted” profes- sional qualifications.

However, this means that the control of oppor- tunities to gain such training or qualifications is crucial to someone’s career progression (Archi- bong, Harvey, Baxter, & Jogi, 2015). This poses a series of questions: What is the impact of career breaks, and what is the mechanism of transfer of disadvantage in relation to career outcomes? Is it a product of the loss of relevant human capital or restricted access to training or both?

Career Breaks and Part-Time Working

Women commonly have disruptions to their career due to family commitments, and these can prove detrimental to career outcomes (Mul- doon & Reilly, 2003; Sanders, Hrdlicka, Helli- car, Cottrell, & Knox, 2011; Whittock, Edwards, McLaren, & Robinson, 2002), although the insti- tutional context is important (Valentova, 2012). Women’s career breaks, mainly for child caring, have negative effects on their ability to progress from one grade to another in their long-term careers (Bosson, Prewitt-Freilino & Taylor, 2005). Neugart (2008) suggested that breaks in employ- ment had a direct correlation to the accumulation of human capital. In addition, negative percep- tions from coworkers about career breaks may be exacerbated by beliefs concerning turnover costs, principally the high staff turnover associ- ated with women leaving employment in order to take care of their families and children (McIntosh, McQuaid, & Munro, 2015). Gregory and Connolly (2008) argued that employers frequently regard

career breaks as periods during which a person’s

human capital not only fails to grow but actually deteriorates or stagnates.

Davey, Murrells, and Robinson (2005) argued that the inability to accrue human capital was also related to flexible working, which compounded the problem due to insufficient continuing pro- fessional development and career opportunities. Part-time working means that this particularly affects female nurses with child care responsibili- ties. In contrast, continuous and full-time work was associated with the accumulation of human capital and was positively perceived by employ- ers (Dex & Sheibl, 2002; Manning & Robinson,

2004). Organizations tended to give preference and privilege to continuous employment, dis- proportionately disadvantaging women who had taken a career break, or those who move into agency or bank work (Tailby, 2005). Manning and Petrongolo (2008) argued that women with chil- dren (or child care responsibilities) spend less time in the labor force than men and accordingly have less opportunity to invest in the accumulation of marketable human capital. As part-time work is mainly offered in response to staff requests, part- time posts are often not integrated into the train- ing and skills development processes by manag- ers, especially for senior posts (Gash, 2008).

Cohen and Huffman (2003) considered that women’s gender resulted in women working part-time and acquiring less labor market expe- rience, which is linked with the gendered nature of household responsibility. Family responsi- bilities resulted in women withdrawing from the labor force, on either a temporary or permanent basis, thus handicapping their careers (Cromp- ton, Brockman, & Lyonette, 2005). This division of responsibilities suggested that women accu- mulated less employment-related human capital in comparison to men and were less attractive to

the labor market. The inability to accrue human

capital was related to the career breaks an indi- vidual took. Unbroken employment experience was privileged within paid work variations, and breaks handicapped and restricted both oppor- tunities and careers. Kersley et al. (2005) noted that organizations tended to give preference and privilege to continuous employment, while the handicapping of women who had taken a long- term career break became disproportionate. Thus, women who spend less time in the labor force than men accordingly have less opportunity to invest in the accumulation of marketable human capital or access to training.

This article will therefore consider two sepa- rate but interlinked issues—women’s access to and receipt of training after a career break, and the accrual of human capital. It examines whether behavior exists that prioritizes full-time workers over nurses’ returning from a career break and part-time workers in relation to accessing post- registration training.

**Methodology**

Permission for this research was granted in August

2010 by the U.K. National Health Service (NHS), National Research Ethics Committees (NREC), to minimize personal and professional risk. In addi- tion, approval was given by the Research Ethics Committee of the relevant Health Board before the processes of recruiting 32 registered nurses commenced. The ethical processes ensured that the interviewees were not compromised and the research was nonexploitative. Those interviewed were 21 to 60 years of age and were employed as registered nurse Grade 4 (which was included in the current Band 5 level) to “senior nurse man- ager.” The Whitley Council grading structure placed nurses on “grades” between 1 and 9, with

1 being the most junior and 9 the most senior

(ISD, 2014). Professional nursing is recognized by registration with the Nursing and Midwifery Council. Registered nurses are individuals who have met the educational and technical standard of proficiency for registration and who are held on the register as a person who is capable of safe and effective practice. Those who have not completed this level of training and were employed on Whit- ley Council Grades 1 to 3, while registered nurses, were employed on various grades between 4 and

9 (NHS, 2009). Grade 4 was the entry level, with promotion to a higher graded post dependent on skill development or training. Twelve of the inter- viewees had some management responsibilities (Grade 8 staff combined management with patient treatment, with Grades 9 and 10 usually employed as full-time managers). They worked on a full- time or part-time basis; some, but not all, had taken career breaks (Table 1). This group, through their direct experiences, were able to identify cur- rent, historical, internal, and external barriers to their careers.

The nurses interviewed were all employed in “acute” nursing. Acute nursing care is short-term nursing care for patients with acute, chronic, or surgical conditions. This was selected because it is the largest area of employment within nursing, possessing the greatest number of disciplinary specialties and offering a variety of career trajec- tories. The Health Board selected is a major NHS employer in Scotland. This employer, by virtue of its size, has a considerable breadth of career movements, variety of working conditions, and diversity of staff in relation to personal circum- stances. The nurses were selected from the one hospital due to the extent and nature of their experiences acquired across different registered grades, employment conditions, nursing areas, and their various family circumstances. Different

Table 1

**The Characteristics of the Nurses Interviewed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nurse | Grade | Age | Length of Service in Years | Full-Time (FT)/Part-Time (PT) | Children |
| Anne | 8 | 45 | 24 | Continuous FT | None |
| Barbara | 8 | 53 | 26 | FT | Two adult children |
| Carol | 5 | 50 | 23 | FT, previously PT; career breaks totaling six years | Two adult children |
| Debra | 5 | 39 | 17 | Three-year career break; previously FT, now PT | Two teenage children |
| Elaine | 9 | 52 | 25 | Career breaks totaling six years; F/T | Two adult children |
| Felicity | 4, now 5 | 51 | 27 | Two career break totaling six years; FT, now PT | Three adult children |
| Georgina | 8 | 31 | 8 | FT | None |
| Hermione | 9 | 51 | 26 | Two career breaks totaling seven years; FT, then PT, now FT | Two teenage children |
| India | 5 | 37 | 15 | FT | Two children under 12 |
| Julie | 10 | 60 | 32 | Career break of eight years; FT, then PT, now FT | Two adult children |
| Karen | 7 | 56 | 28 | Three career breaks totaling seven years;  currently PT | Two adult children |
| Lisa | 5 | 45 | 8 | FT | One adult child |
| Maureen | 5 | 35 | 14 | Two career breaks of three years; FT, then PT, now  FT | Two children under 5 |
| Natalie | 4 | 47 | 25 | Three careers breaks totaling nine years; PT | Two adult children, one child under 16 |
| Olive | 5 | 29 | 7 | Two career breaks totaling 20 months; PT | Two children under 5 |
| Patricia | 6 | 33 | 11 | Continuous FT | None |
| Queenie | 7 | 36 | 11 | Continuous FT | One child under 5 |
| Rebecca | 8 | 33 | 9 | Continuous FT | None |
| Susan | 8 | 36 | 17 | Continuous FT | None |
| Tricia | 4 | 39 | 16 | Two-year maternity leave; FT, now PT | One child under 12, one child under 5 |
| Unice | 5 | 35 | 12 | Two-year career break; FT | Two children under 5 |
| Violet | 4 | 38 | 6 | Ten-year career break; FT (E), now PT (D) | One child under 12, two children under 5 |
| Wilhelmina | 5 | 22 | 1 | Continuous FT | None |
| Xania | 8 | 28 | 7 | Continuous FT | None |
| Yana | 4 | 37 | 16 | PT | One child under 12, one child under 5 |
| Zania | 4 | 26 | 4 | Continuous FT | None |
| Senior nurse  Angela | Manager | 47 | 26 | Continuous FT | None |

(continued)

Table 1 Continued

**The Characteristics of the Nurses Interviewed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nurse | Grade | Age | Length of Service in Years | Full-Time (FT)/Part-Time (PT) | Children |
| Senior nurse  Beatrice | Manager | 57 | 35 | Continuous FT | None |
| Senior nurse  Christine | Manager | 41 | 19 | Continuous FT | None |
| Senior nurse  Diane | Manager | 48 | 30 | Continuous FT | None |
| Senior nurse  Elspeth | Manager | 44 | 25 | Continuous FT | None |
| Senior nurse  Faith | Manager | 51 | 30 | Career breaks, two years; FT, then PT, now FT | One teenage child |

backgrounds and experiences provided an oppor-

tunity to gain insight to influential factors relat- ing to gender perceptions and career progres- sions. The areas of examination were derived from the quantitative research and gaps within it. Table 1 describes the characteristics of the nurses interviewed.

Selection of interviewees was based on a quota sampling method to ensure that the required groups selected for interviews covered a variety of experiences across different registered grades, part- and full-time working, employment conditions, nursing areas, and their different fam- ily circumstances. They had either worked full- time continuously or had worked various hours throughout their careers prior to having taken career breaks. They are detailed in Table 2.

Recruitment took place after liaising with NHS managers, nursing management, and human resources departments. In the first instance, the research purpose was detailed to the senior man- agers via e-mail, followed by face-to-face meet- ings. Following ethical approval, those identified as meeting the criteria for interview were asked

to participate in the study and were formally con-

tacted by letter. Participation was entirely volun- tary, and those involved were fully informed as to the purpose of the research. Data were analyzed using content analysis to generate themes and subthemes (based on an iterative process; Mor- gan, 2008), that involved a detailed and repeated review of each interview transcription. Following each interview, the transcription was scanned and manually highlighted. As different themes were identified, they were assigned an individual code. Once each transcript had been deconstructed and conceptualized, comparisons of emergent themes were made. Classified patterns (Table 3) emerged: specific themes were identified and placed within the corresponding pattern. The thematic analy- sis required the combining and cataloging of the related patterns into subthemes.

Themes were derived from patterns such as conversation topics, vocabulary, recurring activi- ties, meanings, and feelings. In gathering sub- themes to obtain a comprehensive view of the information patterns, when patterns emerged they were discussed directly with the interviewee.

Table 2

**Interviewees’ Length of Service**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Length of Service in Years | 1–5 | 6–10 | 11–15 | 16–20 | 20–25 | 26–30 | 30–35 |
| Age 20–24 years | 1 |  |  |  |  |  |  |
| Age 25–29 years | 1 | 2 |  |  |  |  |  |
| Age 30–34 years |  | 2 | 1 |  |  |  |  |
| Age 35–39 years |  | 1 | 4 | 4 |  |  |  |
| Age 40–44 years |  |  |  | 1 | 2 | 1 |  |
| Age 45–49 years |  | 1 |  |  | 2 | 1 |  |
| Age 50–54 years |  |  |  |  | 1 | 3 | 1 |
| Age 55–60 years |  |  |  |  |  | 1 | 2 |
| Total | 2 | 6 | 5 | 5 | 5 | 6 | 3 |

The validity of selection was achieved by referring

back to the literature. Once the themes had been selected and reviewed against the literature, the themes were finalized. This article emerges from these processes, the interviewees’ recollections and their collective experiences. All study partici- pants were provided with pseudonyms.

**Findings**

Impacts of Career Breaks

There was a consistent belief among those inter- viewed that the length and frequency of career breaks impacted on a nurse’s skills base. The

Table 3

**Themes**

|  |
| --- |
| Grades, qualifications, length of service |
| Full-time and part-time working |
| Age, number of children, age of children, and other personal circumstances |
| Social network—family, parents, school, work, and friends |
| Key factors affecting interviewee moving into or out of work or staying out of work (e.g., career breaks) |

greater the length of the break, the greater the per-

ception that it compromised a practitioner’s tech- nical skills and competencies. Carol stated, “Career breaks interrupt this experience and compromise it. Good practice is dependent on maintaining and continually updating skills. If a nurse has a long- term break, her skills can quickly become redun- dant.” Interviewees strongly believed that nurses who had taken career breaks longer than three years in total were considered by their cowork- ers to be less qualified in terms of current clini- cal knowledge. As a result, they felt excluded or disqualified from senior nursing posts, as Xania elaborated:

Clinical knowledge and experience are the cornerstones of nursing. Professional prac- tice changes so rapidly that when someone takes a break of a few years, that in-depth understanding of technical competencies quickly becomes obsolete“core” compe- tences never really alter but they are an es- sential but small part of “acute” nursing.

Among those interviewed, nursing prac- tice and the ability to develop and maintain that

practice appeared to be intrinsically linked to

continuous service and continuous career devel- opment. This relationship between the quality, depth, range, and length of nursing practice was perceived to be a critical arbiter in career out- comes. Tricia reinforced the importance of the speed of change in acute nursing and stated:

When a nurse takes a career break apart from their service being broken, a nurse’s experience and knowledge is compro- mised. Nursing changes so rapidly, any break in service has a serious implication.

Interviewees strongly believed that career breaks had a detrimental impact on career out- comes because there was a perceived link between unbroken continuous nursing service and the quality of the skills of the practitioner. Those interviewed overwhelmingly believed that career breaks had the greatest negative impact in “highly technically skilled” areas of nursing, for example, surgery and intensive care. Barbara suggested, “Technical knowledge quickly becomes obsolete, (which) career breaks severely impact on and pro- foundly’ diminished.”

This view of coworkers losing key skills fol- lowing career breaks appeared to be as a conse- quence of the deterioration in perceived human capital. Interviewees suggested that in some areas of nursing, career breaks did not have the same effect as “fewer skills” (such as care of the elderly) were needed and the same levels of knowledge and skills were not required. In those areas, career breaks were more acceptable, as changes in tech- nology and practice were less rapid and it did not “greatly” affect a nurse’s effectiveness. Rebecca stated:

Look, in care of the elderly you can leave and come back and reenter the profession

because the skills needed to do this job

don’t really change, but that is not the case throughout nursing. In certain en- vironments, this is certainly not the case. For example, the skills needed for work- ing in intensive care nursing are far more advanced. If you are really serious about making nursing standards, these skills have to be continually maintained and safeguarded—nursing is not a hobby to be fitted in; it is a career.

These remarks exposed the important differ- entials between care and technical knowledge in nursing (Robinson & Griffiths, 2007). Wilhelmina believed that these are pivotal perceptions that define career outcomes: “Care skills never leave you. It’s like riding a bike, but technical knowl- edge must always be updated—that’s the nature of the beast.” She also distinguished the importance of differences in competences and skills between nurses, irrespective of whether they took career breaks, adding, “Some people who never take a break are bloody hopeless, and some of the best people I’ve ever worked with have had five breaks of service.” However, there was a consensus that career breaks reduced a nurse’s level of knowledge and experience. Beatrice argued:

Career breaks invariably lead to a form of restricted working, usually in areas of nursing which require the minimum levels of technical proficiency. These areas do not provide any form of career development or training, and by default, career opportuni- ties become limited. Care of the elderly is the graveyard for nurses for that very rea- son. The nurse becomes trapped in a Catch

22, one that is very difficult to break out of. Simply, once you take a break, your knowl- edge depreciates.

However, even in those areas, the expectations

of patients and clients change quickly, requiring essential retraining and updating of nurses’ skills.

Career breaks and gender clearly had an impact on career progression and access to train- ing opportunities. Unice stated, “When I returned, I returned on a lower grade and I was not alone.” Indeed, this was not a unique experience. It was experienced by all those interviewed who had taken a career break. The length of career break was an important factor, not only because of what occurred after it. Namely, women often returned to work part-time and there was restricted and limited access to training, but also it was located within a gender context. However, this debate is not located in a stark binary division of men ver- sus women but a setting of many combinations: women without children, women with adolescent children versus women with children of school age, and so on. Georgina stated, “It really isn’t about gender, but it is everything about … being a woman. All our careers are linked to children, and as I’ve yet to meet a man that has had one, it comes back to that issue.”

There are powerful factors that reflect inter- nal disciplinary tensions within nursing. Nursing is a skill/task-oriented led profession (Robinson & Griffiths, 2007). Therefore, perceptions concern- ing the perceived (or actual) loss of professional knowledge and technical competency severely impact on female nurses who have a career break. This supports Gregory and Connolly’s (2008) posi- tion in terms of impact but is a complicated area confused by cause and effect—women reentering the workforce in nursing after a break in service do not always reenter at the same grade, and they almost invariably reenter on reduced hours and often at a lower grade (McIntosh et al., 2012). Such nurses may consequently return to more junior posts than what they had prior to their career

break, due to their own feelings of diminished or

redundant skills, as well as other family responsi- bility pressures. The means of transference lead- ing to these outcomes is discussed in the following section.

Training after a Return from a Career Break There were strong opinions among a significant number of the interviewed nurses that the lack of appropriate training to upgrade skills upon reen- try to the profession was a key issue. The lack of training produces a negative circular trajectory: “no training,” therefore “no promotion,” and con- sequently “no incentive” to change working condi- tions or patterns. These concerns were particularly strong among returning practitioners’ comments on the absence of the availability of training after their career break. Julie stated:

Nursing skills have to be upgraded if re- turning nurses are to be allowed to per- form the whole task. They need the former to complete the latter. When I returned, I was given no opportunity to update my skills. It was as if I was worthless—it was a steep descent from valued to undervalued.

India was more adamant:

It is essential in nurse practice that the practitioner possesses the vocational knowledge to resolve clinical issues. If returning nurses are to develop their ca- reers, they need training to upgrade the skills. Most, and I include myself in this, are forgotten.

If the findings are indicative of the general values prevalent in the profession, then it appears that the nursing profession acknowledges the need for training but is unable to reconcile the profes- sion’s values with structural barriers to training,

such as who is prioritized for training and the

availability of training for those returning to work. Some nurses accept such a position or feel power- less to change it. Hermoine stated:

As a general rule of thumb, nurses with continuous service have a greater knowl- edge, they (have) got the time to update their skills. They are prioritized at every juncture. I don’t argue if this is right or wrong; it is just the way it is.

For returning nurses, there was in general an absence of training courses provided especially for specialized nurses. Faith stated:

My first career break lasted for a few years, and I was a bit rusty when I returned, but there was nothing there for me in surgery. Such was the degree of the problem I had to leave. Experienced nurses were left to vegetate.

Anne reflected that the lack of training pro- vided was due to the demand and supply in the nursing labor market rather than management incompetence:

I originally thought it was just sheer stu- pidity or sheer prejudice or sheer incom- petence. I then thought it was a mixture of all these things. As it seems so counterin- tuitive, it slowly dawned on me that it was all related to supply and demand—with a constant supply of “new” nurses, it was easier to recruit them than go through the time-consuming process of contacting, en- gaging, and then facilitating the training needs of nurses on a career break or those returning from a break.

This was a theme touched upon by many of those interviewed. Elspeth stated:

It is just easier to appoint a “freshly mint-

ed” qualified nurse. Nurses who have just got their degree have more up-to-date skills and invariably cost less, as they are put on the bottom or near to the bottom of the salary scale.

This situation was freely acknowledged, but there were also other issues at play such as flex- ibility of attitudes. Queenie reflected:

A major advantage of this recruitment policy goes beyond the financial. Newly qualified nurses can adapt more easily to the constant changes of practices. They have not developed “bad” practices and are more willing to accept change. It is the old adage: Get them when they are young.

There was a more surprising response that summed up a pervading feeling within these interviews. Xania believed, “Quite simply—you can’t teach old dogs new tricks. It is not worth the effort.” There were many contradictions contained within these statements. If nurses had been “con- ditioned” by training processes, how could their worth as a practitioner be so dramatically changed by a career break?

The answer to this question emerged when the issue of budgets was examined in greater depth. Two themes emerged, linked to cost-effectiveness and, more critically, perceptions related to full- time working. Diane argued:

Look, we only have a limited budget for training within the hospital—training is ra- tioned. There is no bottomless pit of cash. If there was, we would know how to spend it—I can assure you of that! We all know there have always been heavy financial constraints within the NHS; it would be wonderful to train everybody who wished

it, but if we did, we would treble the size of

the training unit and it would make us in all probabilities no more efficient.

Maureen explained:

Rationing happens for a reason not neces- sary related to demand but supply. When we are making decisions as to who should receive training, we have to ask ourselves not just who would most benefit from training but who would make the most contribution to the patient.

Within this evaluation full-time permanent working was prioritized. Debra observed, “I make no judgment as to the worth of those request- ing training, but we have no time to train. Until we have pots of cash and health care delivery becomes fundamentally different, it must be full- time working all the way.” When questioned on what she meant by the latter comment, she added:

The demands of the jobs are so great, how can we keep skills up to date while deliv- ering care and quality health outcomes? The only way that this can be achieved is through a full-time dedicated workforce. It is as simple as that and I can’t see this changing anytime soon. Full-time working is still the most efficient and cost-effective means of delivering quality patient care. We must prioritize those full-time nurses in post for the good of the patient and the service.

Many of the interviewees considered these perceptions to full- and part-time working as an unfair process and an inefficient use of resources. Natalie stated, “Nurses still have the same core competencies and experience after a career break.” This caveat was not restricted to those

returning from a career break but influenced deci-

sions in relation to part-time nurses, “regardless if they come back as a full-timer or a part-timer … all they need is training. If you go part-time, the opportunity to address this is very restricted.”

Despite training being essential to the opera- tion of nursing, especially in more technical areas, the reasons given for the lack of training for those taking career breaks and/or working part-time include labor market demand and supply factors, which was related to the perceived advantages of taking on cheaper newly qualified staff; the lack of flexibility; the costs of training; and the need to prioritize full-time workers in terms of maxi- mizing the return from training and due to the nature of the job supposedly requiring full-time work. Arguably, the perceptions of nursing, as a task-oriented and a task-led profession (Robin- son & Griffiths, 2007), concerning the perceived (or actual) loss of professional knowledge and technical competency could severely affect a prac- titioner’s career. Accordingly, education, work experience, and career breaks are central arbiters in the acquisition of a nurse’s perceived human capital and the worth subscribed to it. It is clear from these interviews that women’s career out- comes are affected by career breaks and that it is a significant inhibitor of female nurses’ perceived human capital and subsequent career progres- sion. This is due to operational pressures, finan- cial constraints, and the constant supply of new practitioners.

It is paradoxical that the human capital nurses accrued prior to the career break is per- ceived to be so diminished upon return—that nursing skills and experience are viewed as either obsolete or redundant. It is understandable that skills may deteriorate in areas of rapid techno- logical change, but this is not applicable to core skills and competencies such as compassion or

leadership and management skills, which should

not be so affected by career breaks. It can in part be explained by disciplinary perceptions related to rapid changes in technology and the pres- sures related to constantly supplying practition- ers to deliver these services. This creates a situa- tion in which perceived operational and financial rationales facilitate an untransparent bias against a group of workers. The economic and delivery pressures make it easier to recruit a new practi- tioner than invest in training a practitioner after a career break, and it is this that phrases the nar- rative in relation to training and career oppor- tunities in nursing. This “upgrade” or “buy new” dilemma exemplifies this process in relation to employment. This process is equally pronounced in relation to part-time nurses, and this will be discussed in the following section.

Training for Part-Time Nurses

Nurses who returned after a career break were affected in terms of the access to and receipt of training. Those who had returned to work part- time working were doubly affected. Olive con- veyed this and her frustration:

It’s annoying because though I was will- ing to go to training courses when I was on maternity, I wasn’t allowed to go to them, and over time I just didn’t have cer- tain technical competencies which are es- sential for promotion. … If that wasn’t bad enough, I have nine years experience and yet someone with far less real experience will get the (promotion) post because they work full-time and can go to all the train- ing available.

The above comment was not unusual. Patricia reiterated this and outlined the difficulties she had recently experienced:

When I returned from my career breaks,

it was difficult combining work with child care. So I went part-time and applied to take courses, but they were rigidly timeta- bled. I couldn’t go to them. Though I want- ed to develop my skills, I was presented with no options.

She was asked whether they had provided an explanation or offered to rearrange it and stated:

When I asked about it, I was told that due to demand, timetables could not be indi- vidually tailored. They said if they could, they would, but that those providing the training could only do it at that time.

Yana commented:

When I asked for training, I was given ev- ery excuse under the sun, but at the end of the day, the full-timers were always prior- itized ahead of the part-timers. I can’t say I had no complaint—I did.

Violet commented on the type of training available and observed:

Part-timers are the backbone of nursing— we make up half of the workforce,1 but we are the poor relations in terms of training. If we do receive it, it is not technical skills– based training, which is essential to career development.

It is significant to note the lack of techni- cal training, yet these skills that were important in terms of the criticisms (above) of those taking career breaks. She added:

We part-timers are in a Catch 22 situa- tion. We normally occupy the lower grad- ed posts, and without the opportunity to

receive training we cannot progress. Mak-

ing a case for training is easy, but that does not translate into action.

The link between rationalizing and justify- ing the expense incurred for training was an issue linked to nurses working part-time. Christine stated:

In a time of restricted resources, it is hard to justify training for part-timers; they are transitory workers. They make a magnifi- cent contribution to the service. There is absolutely no denying this as it is a fact, but—and there is a big but—training is rationed, and the rations must be given to those who are stickier—those that will stick around. It has to go to the full-timers. It has always been this way and I cannot see that changing anytime soon. There would have to be a massive change in the culture within and outside of the profession.

This discussion was not isolated. Tricia considered:

Part-time nurses are condemned by an un- healthy mixture of a stratified and unques- tioning culture and a highly bureaucratic organization that consider full-time work- ing to be best. The belief does not allow the career development of nurses.

Lisa opined:

When nurses go part-time, they stay there apart from moving horizontally; the oppor- tunity to move vertically is limited. They can only move when they receive training.

Those nurses who had received some form of training during their career breaks experienced a material benefit in terms of their career outcomes. Christine highlighted this:

I received training before and upon my

return, and it made a world of difference in terms of grade. I went from a 5 to a 7 quite rapidly. … (Slight pause) I think I got it within two years.

There is a clear link between these issues. However, when this is considered in tandem with the apparent low status ascribed to part- time workers in comparison to full-time workers (McIntosh et al., 2015), due to a perceived lack of flexibility and continuity, a situation is created that facilitates restricted career outcomes for part- time members of staff.

Within nursing, the greater importance ascribed to full-time working in comparison to part-time working is pronounced and determines access to training and development opportunities. This finding is significant. If career opportuni- ties were strongly linked to nurses’ qualifications and enhanced skills, the inability to acquire these qualifications and skills would severely restrict the practitioner’s career outcomes. All those inter- viewed acknowledged that training was rationed. Although there appeared to be an established pro- tocol in relation to accessing training, its organi- zation and scheduling disproportionately affected those nurses who worked part-time, unsocial hours, or night shifts. It is dubious to argue that rights to access training are safeguarded—they exist notionally.

Decisions about who receives training are underpinned by financial considerations and a bias toward nurses who work full-time, which actively deny access to training to other nurses. It would appear that full-time working is still considered the most productive and economic means of delivery. This effectively reduces the careers of an entire cohort of female nurses. They become the lost generation. Women, particularly

mothers, disproportionately suffer not because

of direct sexism but by a set of circumstances that make it normal and acceptable. This posi- tion is directly related to child care and associ- ated breaks and part-time work. This is correlated with gender (due largely to gendered child care), so it is partly a fallacy to state that only gender is the issue.

**Discussion**

The exploratory research in this article identifies that in addition to the influence of career breaks themselves (Brown & Jones, 2004), and associated factors such as skill redundancy, it is subsequent access to training that significantly worsens career progression. These are major apparent obstacles to women’s career advancement in nursing, gen- der and children being foremost. These are exacer- bated by the evident restrictions to access training, particularly for part-time nurses, nurses working unsocial hours, or nurses returning after a career break. However, these restrictions are ultimately detrimental to the operational efficiency of health care delivery.

Nursing is a labor-intensiveprofession, and maximizing the use of all staff is critical to deliver high-quality care. To reconcile all of these issues, change is essential. The nursing profession therefore has to choose—to use and maximise the skills of all its practitioners or to accept the deskilling of a significant section of the workforce (Prowse & Prowse, 2008). Accepting the dimin- ishment of those nurses who have by choice or necessity taken a career break or who work part- time is neither economic nor socially acceptable in the long term.

There is a way forward: While absent on a career break, and on their return to employment, nurses should be offered ongoing training to

maintain their skills. The skills base of nurses who

return from a career break should be evaluated and training provided. Indeed, all grades of nurses should be afforded support in getting access to and receiving training, and the timing and length of courses should be altered, if needed, to accom- modate part-time practitioners. In order to reduce the restricted opportunity of women with child care responsibilities, accessible training and learn- ing pathways at a national, regional, and local level, and suitable recognition of prior learning should be put in place. Enhanced learning frameworks to support access to education and training so that all nursing practitioners should be developed, particularly those returning and part-time practi- tioners. The U.K. government’s policy on Shared Parental Leave and Leave Curtailment came into force on April 5, 2015, to make parental leave shareable, with the objective to challenge assump- tion that women will always be the parent that stays at home. Lessons from previous experiences of similar legislation in Europe (Ekberg, Eriksson, and Friebel, 2013; Tavistock Institute, 2014) must be applied effectively to reduce this continuing gender penalty on the nursing workforce.

These measures represent an opportunity to enhance all nurses’ career outcomes, particularly those with dependent children. It can prevent the permanent loss or curtailed career development of the most highly trained and skilled members of staff. This is advantageous and desirable for the employer and the nursing profession. These recommendations would support the possibil- ity that women, particularly those working part- time, those returning from career breaks, and those with dependent children of all ages, could meaningfully continue to develop their career. It can directly benefit the financial and opera- tional efficiency of the employer. The retention and return of experienced registered nurses can

76

reduce the ongoing expenditure on the training of

new staff. Reengaging and retaining experienced nurses would further enhance the quality of care provided by the service. This notwithstanding, it is also a necessity for the NHS if shortages in registered nursing are not to become chronic in the near future due to demographic changes. For nurses, these proposals can enhance the work–life balance and positively confront the choice many women are presented: between their career and family.

Rapid improvement in health care technol- ogy and the constant need to provide high-quality health care have created a constant demand for highly skilled nurses who are informed by up- to-date training and practice. For financial and economic reasons, some interviewees consid- ered that their employer (NHS Trust) believed it was more effective and desirable to recruit from the pool of newly registered and newly qualified full-time practitioners as opposed to investing the same amount of funds in staff returning from a career break or who work on a part-time basis. Investment in training is principally directed at this group. Financial restrictions have been ever present within health care delivery and produce direct and indirect rationing of goods and services. The provision of training is not divorced from this situation. When this is com- bined with organizational values that prioritize full-time working as the desired and preferred form of working, the situation arises that makes it ever more difficult for those employees who work part-time to access and receiving train- ing. As qualifications and training significantly determine career progression, these groups’ careers are directly and negatively affected. The findings also suggest that a purely human capi- tal approach, which focuses on meeting exist- ing demand through increasing the supply of

qualified labor, ignores important equality and

efficiency effects on certain groups.

**Conclusion**

In conclusion, this research builds upon and extends the current literature on gender-based equity. It confirms that nurses who work on a part-time basis and/or have dependent school- aged children have restricted access to the receipt of training. This restricted access to training is a principal mechanism of transfer for career disad- vantage in registered nursing. This expands upon Davey and colleagues’ (2005) position in relation to the restrictions placed on women in relation to accessing training. It confirms the existence of the “snakes and ladders” effect: Prior to a career break, women rise through the grades until they take a career break. Upon return, they start on a lower grade or reduced hours, or both, and have to effectively recommence the careers. The “snakes and ladders” effect has a direct impact on their career progression. This is a new contribution to knowledge. Significantly, this research observes that course discrimination is not restricted to men and women but is prevalent between women with children and women without children to a higher degree than previously considered or acknowledged. The relationship between gender, gender perceptions, and operational values, par- ticularly commitment, working flexibility, and professional values are central to defining career outcomes for men and women. This relationship redefines the narrative of “norms” within gender and employment.

In the final analysis, there is clearly an eco- nomic imperative in relation to the rationing of training, but not retaining those nurses who have returned from a career break or who work part- time compromises patient quality and safety and

is likely to be ultimately a false economy. Nurs-

ing needs to think about the environment and develop strategies to retain the workforce. It is clear that nursing must do more if it is to retain nurses. It must challenge the status quo to give a meaningful equality of opportunity to all prac- titioners. The part-time NHS workforce are directly affected by the restricted and limited opportunity in receiving postregistration train- ing; hence, this is an intergender and an intra- gender issue. The access and receipt of training, as outlined in policies, legally should be fair and unbiased; however, this exists only notionally for some groups. There is an unconscious systematic bias against part-time workers and those return- ing from a career break within nursing, and this bias is partly rooted in the narrative of gender and the gendered nature of child care responsibili- ties. However, it is overwhelmingly mothers and females with child-caring responsibilities who bear the costs of a lack of training support after career breaks and while working part-time. A failure to continue the development of all nurses undermines the profession in the short and long term. Those who suffer this gender penalty are the lost generation, and the challenge is that they should be the last generation who are overlooked and undervalued. ◆

**Note**

1. This is correct in terms of total numbers, but not in terms of full-time equivalents (ISD, 2013).

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