Organisational Culture as a Barrier to Women's Promotion

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Abstract: Over the past five years increasing attention has been paid to the importance of what Witz and Savage (1992) have described as the gendered nature of organisations. This paper focuses on what they have called the "significance of difference" within the context of a discussion of the perceived reality of organisational culture. Using a thematic qualitative analysis of data from 40 focus groups, involving a stratified random sample of 162 women at middle and senior levels of the Administrative, Nursing and Paramedic sectors of two Irish Health Boards, four aspects of this organisational culture are described viz., the perceived reality and implications of a male hierarchical model of authority, the perceived reality of a woman's place in that structure; the perceived marginalisation of female professional projects and the existence of a coping style of Management. The paper suggests that these aspects of organisational culture are by no means peculiar to these Health Boards. Indeed, these Boards are unusual only in so far as they have legitimated a challenge to male hegemonic culture by implicitly valuing "difference", through prioritising the idea that women — who constitute the majority of their staff — should be employed "at the top of their capacity" (Doherty, 1994).

I INTRODUCTION

O ver the past five years, increasing attention has been paid to the importance of what Witz and Savage (1992, p. 6) have called "the gendered process internal to the bureaucratic process of the State". This paper is concerned with one aspect of this phenomenon (viz., the gendered nature of organisational culture), as a way of understanding why women are not moving upwards within the Management and Administrative structures of the State bureaucracy defined in its widest terms. The concept of organisational culture is used to refer to the relatively stable beliefs, attitudes and

values which are part of the taken-for-granted reality in organisations and which are reflected in its structures and organisational procedures. In this paper the focus is on those which reflect and reinforce a particular view of women and women's place within these organisations. In so far as one sees Health Boards as part of the integrative apparatus of the State (as suggested in Franzway, *et al's* framework, 1989), the issues which are being raised by Witz and Savage (1992) can be seen as relevant to an understanding of the position of women employees within the State apparatus as a whole.

It is worth noting that these structures are not being seen as inherently patriarchal (as McKinnon, 1987 suggested); or as inherently capitalist (as Barrett, 1980 suggested) or even simply as both patriarchal and capitalist (as Walby, 1990 suggested). Rather, the implicit assumption is that, as part of the State apparatus, they constitute a site where power is contested within the context of what Connell (1987, p. 184) has called "hegemonic masculinity" i.e., "a social ascendancy achieved in a play of social forces that extends beyond contests of brute power into the organisation of private life and cultural processes". Davies (1995, p. 44) has suggested that in this context organisations must be seen as "social constructions that arise from a masculine vision of the world and that call on masculinity for their legitimation and affirmation". In such a world "women's place" is defined by men and it is a subordinate one. Women can attempt to move upwards by "ignoring difference, acting as equal" (Davies, 1995), becoming "surrogate men" (Carey, 1994). This strategy can be very successful at an individual level. However, it leaves the hegemonic patriarchal culture intact, and is inherently fragile, since such women's status as honorary males may of course be withdrawn at any moment.

Implicit in this paper is the idea that hegemony is never total, that alternative discourses may exist, and that challenges to the hegemonic organisational culture may be legitimated and even promoted in the interests of organisational efficiency or effectiveness. This indeed was the stimulus for undertaking the present study of women at middle and senior levels in the Administrative, Nursing and Paramedic sectors in two Health Boards. Three-quarters of all the staff employed in these Health Boards are women (a pattern which is typical since nationally, on average, 71 per cent of all staff are women, although women occupy only 7 per cent of Management and no senior Management positions: Department of Equality and Law Reform, 1994, p. 42). This under-representation of women in Management positions is not peculiar to the Health Boards. Mahon (1991a, b, c) was one of the first to document a similar pattern in the Civil Service, while Lynch (1994) has adverted to it in the area of education. It is also not peculiar to Ireland, with broadly similar trends being identified in the American Civil Service

(Levinson, *et al.*, 1992) and the Canadian Civil Service (Canadian Government, 1990). It is arguably not likely to improve with increasing social and economic development: Portugal and Spain having the highest proportion of women in senior Management positions in the Civil Service in Europe (Rubery and Fagan, 1993).

The traditional approach to this situation has been in terms of an equal opportunities policy. In Ireland, we have typically defined this in a rather narrow way in terms of equality of access (for a description and a critique of this see Callan and Wren, 1994; Mahon, 1991a and b and O'Connor 1995a and 1996). At a legislative level, the main concern has been with providing women with the same access as men to the same or similar work. Furthermore, even in so far as equality has been defined in terms of outcomes (e.g., in terms of the proportion of women at senior level) equality policies have still tended to implicitly rest on assumptions concerning the gender neutral of social reality. Through work such as Halford's (1992) and Mahon's (1991a, b, and c) we have a good understanding of the organisational procedures through which patterns are maintained i.e., involving recruitment, job applications, the range of job experience available to women, visibility, etc. These phenomena were also identified in the present study (O'Connor, 1995a) although they are not the focus of this paper. They are very much part of what Cockburn (1991) has called a short equality agenda, but they are not sufficient to enable one to understand the gendered nature of such bureaucratic structures (Davies, 1992; Witz and Savage, 1992). Equally, although Walby's (1990) concepts of segregation and exclusion, and Witz's (1992) somewhat similar concepts of exclusionary and demarcatory closure, are useful in helping us to perceive specific organisational procedures as part of an attempt by one group (men) to define another group (women) as "ineligible" for particular positions, they do not really help one to capture the gendered reality of organisations. Positive action programmes do attempt to deal with this reality, and have been described as

> a response to the perceived need to address the effects of apparently neutral, but effectively discriminatory processes which have built up in the system as a result of a history of inequality (Callan and Wren, 1994, p. 68).

Typically in Ireland such positive action programmes, in so far as they exist, are exhortatory (in the sense that they are concerned with the identification of targets rather than quotas) and focus on increasing individuals' abilities to compete (through for example single sex training). They do however play an important part in raising awareness about the gendered

nature of social reality and in mobilising support to tackle the effects of past discrimination (at least at an individual level).

There is a great deal of evidence which shows that the gendered nature of occupational life is systemic and all pervasive (Durkan, *et al.*, 1995). Thus, typically men and women perform very different kinds of paid employment and these are differently valued (i.e., in the sense that paid activities performed by men and/or areas of predominantly male employment typically have higher pay, and better working conditions, promotion prospects and access to training). The European Commission has recognised the need to reassess the value of jobs traditionally performed by women, as well as "opening all levels of seniority to women" and "implementing gender — neutral job evaluation and job classification schemes" (EC, 1994, p. 42). This type of thinking was reflected in the recent decision by the European Court of Justice (1993) that a woman worker might be considered a victim of sex discrimination if she worked in an overwhelmingly female profession, whose members were appreciably less well paid than members of comparable professions, where, at an equivalent level, there were more men than women. The claim was made by a Senior Speech Therapist in Britain (Dr Pamela Enderby) whose pay was substantially lower than the pay of Principal Clinical Psychologists and Principal Pharmacists in the Frenchay Health Authority, although all three had training to a similar standard. The case thus raised the whole question of the extent to which areas of predominantly female employment (such as Speech Therapy) were likely to be less well paid than areas which were less feminised. The case was dealt with in the context of Article 119 of the Treaty of Rome, which deals with equal pay. Within Irish equality legislation where the focus has been on establishing comparisons between like or similar work, it opens up a new dimension. Within this latter context, it is useful to see it as raising issues related to "difference".

The issue of "difference" involves a recognition and a valuing of the social, cultural and other differences between groups (such as men and women) as opposed to simply valuing those who become "assimilated", those who forgo "difference", and become in this case "token men". Cockburn (1991) has suggested that the issue of "difference" is part of what she calls the "long agenda" of equality, involving as it does the fundamental restructuring and valuing of a range of organisational cultures (as opposed to simply those valued by "hegemonic masculinity"). The implications of a concern with "difference" do not of course solely involve women, but potentially include "difference" at a racial and disability level. In this paper, however, the key focus is on gender. It will be argued that even in areas of predominantly female employment (such as the Health Boards) the very structure itself as reflected in the lines of authority, the differential rewards and opportunities

available to those in different sectors as well as the set of assumptions about men, women and Management which are part of the organisational culture reflect and reinforce women's subordinate position.

In this article, through the eyes of these female employees in the Midland and Mid-Western Health Boards, the kind of organisation which is presented to them as "normal" is described. It is a hierarchical structure which is characterised by one way communication and a retentive attitude to information; it is a structure where women's "proper" place is not in Management; where the "normal" pattern of succession is along a male line; and where areas of predominantly female employment such as the Paramedic and Nursing sectors are characterised by a "coping" style of Management (Davies, 1992) as they become remote from centres of real power. The implicit (male) organisational message is:

> you may find a place as long as you simulate the norm and hide your difference. We will know you are different and continue ultimately to treat you as different, but if you yourself specify your difference, your claim to equality will be nil (Cockburn, 1991, p. 219).

At its most minimal, that specification of difference might simply revolve around maternity. However, implicit in the approach adopted in this study is the suggestion that "difference" arises from being a woman within a structure where the male is the norm, and where male styles of organisation and relating are the basis of the organisational structure and culture.

The focus of this study was not on the re-envisioning of this structure and culture, although it will be shown that in their description of the perceived barriers to promotion, these women do provide some insight into it. The kind of organisation the women were envisioning was one which was very much in tune with current Management thinking in so far as it was team orientated, strong on communication, meritocratic in style and with an ability to use the hands-on expertise of staff, particularly when this was central to the purpose of the organisation. As they envisaged it, this organisation, in its culture as well as in its structure, would reflect and reinforce a positive valuation of them as women contributing to the work of the Health Boards. Implicit in their comments is the concept of an authority rooted in expertise, relevant to the purpose of the organisation, with resources being allocated on the basis of clients' needs rather than male privilege. As they envisioned it, it was a structure where "difference" was accepted, and where, because of the predominance of women within the structure and their centrality in front line caring areas, their particular contribution was not denigrated, and indeed might be especially valued.

The approach which is being adopted then in this paper is typical of what

Witz and Savage (1992) have called a post-modern feminist approach which focuses on the significance of "difference". (This has also been called a diversity approach.) It suggests that the issue is not simply one of attempting to ensure that women are represented in the bureaucratic structures at senior level (the add-one-or-two women and stir model). It is not even sufficient to see these structures as organisations "that represent men's interests as against women's", but as structures which are organised "as if men's interests are the only ones that exist" (Pringle and Watson, 1989, p. 234). The issue is one of "difference", of parity of esteem. Hence, the paper is concerned with exploring the extent to which these structures incorporate a division of labour and authority, as well as a set of assumptions about women and Management, and an implicitly gendered allocation of resources, which is inimical to the promotion of women. There are of course aspects which are clearly amenable to an equal opportunity approach (and these are discussed in greater detail in O'Connor, 1996). This paper will touch on these although it is most centrally concerned with issues of "difference".

The issues emerge in a slightly different form for women in different sectors. Thus, it will be shown that for those in the Administrative Sector (an area of predominantly male employment at middle and senior levels) male prejudice is very much a reality within what they see as an unattractive hierarchical structure. This structure raises issues at the level of "difference", although the impact of this structure is compounded by prejudicial attitudes which arguably could be modified somewhat by an equal opportunities approach. For women in the predominantly female Nursing Sector, the issue of "difference" is much more dominant, and is reflected in the low valuation of Nursing as a female professional project (and hence in its low salary; poor prospects of promotion; remoteness from access to the power brokers within the Health Board, as well as in the paucity of resources over which Nurses, even at the level of Matron, can exercise direct control). There are, in addition, equal opportunities issues, and these are reflected in men's greater possibilities as regards promotion within both General Nursing and in specific areas (such as the Psychiatric area) where discriminatory practices were traditionally institutionalised. Finally, the Paramedic sector, when viewed en masse, is characterised by similar issues as regards "difference" to those which emerge in the Nursing sector. However, it is important to recognise that it embraces a wide variety of professional disciplines, with very different male/female profiles. The numbers are unfortunately too small to allow for separate analysis. However, it is clear, that in particular areas, women have similar experiences of male prejudice and discrimination as their counterparts at the higher echelons of the predominantly male Administrative sector.

From the perspective put forward in this article an important question is perhaps whether women want to participate at senior level in such organisations; how they experience them; and to what extent they are willing to accept this kind of organisational culture even on a short-term basis. There are also general issues about the characteristics of those who are included, as well as those who are excluded, from the senior positions in these structures (Davies, 1992). These issues, however, are not the main focus of this paper. Rather, it is concerned with describing women's perception and evaluation of four different aspects of the organisational culture in these Health Boards, viz.,

1. the perceived reality and implications of a male hierarchical model of authority;
2. the perceived reality of a woman's place in that structure: male prejudice and the chill factor;
3. the perceived marginalisation of female professional projects: expertise v authority;
4. the perceived existence of a coping style of Management: an appropriate option for women?

As one would expect, these themes were differentially important to women in the different sectors. Thus, the first two were particularly but not exclusively relevant to those in the Administrative sectors, and the latter two were particularly but not exclusively important to those in the Nursing and Paramedic sectors. It is also worth noting that those at Senior level were most likely to endorse the hegemonic view, with senior Administrators being the most likely of all to do so.

It is important to note that the Paramedic area includes a wide variety of disciplines. For some of these, the very concept of "Paramedic" is not acceptable, and is seen as implying an inappropriate medical focus and/or a suggestion that these professions are in some way inferior to medicine. Such a suggestion is not intended in this paper. The concept Paramedic is simply used, following these Health Boards' own practice, to refer collectively to a varied group of professions including physiotherapy, laboratory technician, occupational therapy, environmental health, radiography, social work, psychology, speech therapy, pharmacy, etc.

The focus on organisational culture as opposed to family responsibilities as a barrier to women's promotion may seem surprising within an Irish context. However, in the eyes of these women at middle and senior levels in the Health Board structure, although issues related to facilitating the integration of domestic and family responsibilities were seen as important symbols of the Health Board's lack of concern for them as women, the barriers to women's

promotion were overwhelmingly seen as lying within the organisation itself (a pattern which may indeed reflect their age and/or their level within the structure). The concept of organisational culture is being used to capture this subtle and pervasive reality.

II METHODOLOGY

The brief for the study indicated that the Midland and Mid-Western Health Boards were "anxious to ascertain the views and the advice of women on their perceptions of the barriers to promotion in the Board's employment and how these can be removed" (Doherty, 1994). It indicated that the methodology should be focus group discussions: a method which consists in the initiation of a discussion around themes and issues identified from the literature (Morgan, 1988). In consultation with Senior Health Board Management, it was decided to focus on women at the middle and senior levels of three sectors of employment, viz., the Administrative, Nursing and the Paramedic sectors. These areas provide 60 per cent of all Health Board employment in the country, and 68 per cent of the female employment in the Midland and Mid-Western Health Boards (Department of Equality and Law Reform, 1994).

These decisions reflected the Health Board's recognition that women were under-represented in the Management structures of the Health Boards and their concern to encourage female Management talent from these sectors. Within this context an exclusive focus on women obviously made sense, although it meant that women's responses could not be compared with men's responses. This approach is compatible with a theoretical concern with the place of women within a hegemonic male organisation where women make up three-quarters of the employees, but are absent from the top of the structure (i.e., Management team and Grade VIII), and become visible only if one uses a very generous definition of "Senior" posts, i.e., including those who are for example at Grade VI level in the Administrative structure (Salary £19,012 — £21,493 p.a.); Assistant Matron in the Nursing sector (Salary £17,521 — £21,751 p.a.); Senior Radiographers (Salary £17,265 — £22,125 p.a.: December 1st 1993 salaries — see Appendix).

In order to select a random sample of women to be included in the focus group discussions it was necessary to establish equivalencies between the three career hierarchies. A decision was made to do this by looking at the salaries of those in the three hierarchies and effectively imposing a framework of "lower", "middle" and "senior" levels on the very different career structures in the three sectors (see Appendix).

It is important to note that although implicit in the brief for the study was

a concern between the identification of future managerial talent, there is not a one to one relationship between the respondents' position at middle or senior level and the extent of their managerial responsibilities. Indeed, it is true to say that very few of those at the middle or even the senior level of any of the three hierarchies have responsibility for a budget and for staff. Thus, for example, within the Administrative structure, only those at the very top of the senior level (i.e., Grade VII and above) where women are virtually non-existent have responsibility for a budget. Responsibility for staff is more common amongst those at middle and senior levels in the Administrative structure. However, some of those at the lower end of the middle grade (i.e., Grade IV, a predominantly female grade) were in specialist posts where they had no staff working for them. Within the Nursing sector, although those both at middle and senior levels (i.e., Ward Sister and Matron level respectively) had very clear responsibilities as regards staff, Ward Sisters did not hold or control a budget, while the extent of financial control exercised even by Matrons was very restricted (i.e., being mainly confined to hours and premium payments). Within the Paramedic sector, financial control, even at senior level, was virtually non-existent. Furthermore, none of those at Basic Grade in this sector, and only some of those at senior level, had control over staff. Thus, for example, in particular areas such as, for example, Speech Therapy, senior posts were allocated on the basis of specialist skill.

Thus, although this study was focused on women at middle and senior levels of these three structures, with a view to identifying the barriers as regards women's promotion to managerial positions, these women for the most part did not currently hold what would be seen as managerial responsibilities. Indeed, in many cases the only resources they had access to were their own time and energy. It will be argued that this generated what Davies (1992) has described as a "coping style of management" — a style which reflected and reinforced the low level of managerial resources typically made available to these women.

It is beyond the scope of this paper to describe the promotional context of the employees in these various sectors in detail. However, typically within the Administrative structure, employees up to Grade VII were recruited from the "common pool", (employees at a lower level within the same or other Health Boards, Local Authorities, etc.). Employees at Grade VIII or above on the Administrative hierarchy were recruited through open competition. Within the Nursing Sector, access to the posts of Ward Sister and Matron was by promotion, as were the senior posts within the Paramedic hierarchy. However, in some of the latter areas, senior posts were created on a ratio basis (i.e., so many basic grade workers to one senior), and typically did not reflect the qualifications, responsibilities or expertise of the staff involved.

In order to ensure that the sample included those at senior and middle levels of each of these hierarchies, a stratified random sample was used, i.e., selecting roughly one in three of those in each "cell" in each of the two Health Boards, i.e., roughly one in three of those classified as being at the middle level of the Administrative hierarchy in each Health Board; one in three of those at that level in the Nursing area, etc. There was one situation where there was less than five women in a cell (i.e., in the case of senior females in the Administrative hierarchy in one of the Health Boards), and in that situation the coverage was total.

Of the 222 respondents selected, a small number (N = 9) were not applicable (i.e., they had gone on maternity leave; were on unpaid leave; or had resigned). The response rate amongst the effective sample was 76 per cent (i.e., 162/213). Those who took part constituted roughly one-third of the total population in each cell.

The intention was that the focus groups would consist of ten women. However, the pattern of response was such that in fact it was necessary to arrange forty groups. These groups varied in size from 1-8 people, with an average size of 4.05. It was made clear to the women at the beginning of each session that it would last one hour and this was the predominant pattern. At the beginning of each session, it was also made clear to the women that the initiative for the study stemmed from the (male) Chief Executive Officer. Thus, a context was created whereby comments which could be construed as critical — even subversive — were legitimated. The group discussion was recorded manually (verbatim), since there was, particularly at the beginning of each session, quite a good deal of anxiety about the confidentiality issue and about the perceived risks of "speaking one's mind". This material was analysed thematically within each sector, all statements involving the perceived attractiveness of Management and references to gender as an aspect of organisational culture being extracted. This material was then re-organised in terms of the theoretically significant themes outlined in this article, deleting repetitious quotations, etc. A similar process was undertaken in the case of three other themes, viz., those relating to organisational procedures; to the combining of paid employment with domestic and family responsibilities; and to the identification of specific equal opportunity initiatives (see O'Connor, 1995a and 1996), although these are not the focus of this paper.

The material emerging from these focus group discussions relating to organisational culture is what is being presented here. Typically this material emerged either in response to general triggers, i.e., asking them what they saw "as the barriers to women's promotion in your area"; what they thought "increases a women's chances of being promoted" and "what reduces her chance of being promoted"; or more specific triggers about

whether "Management and/or supervisory positions are attractive to women", and whether (in the case of the Nursing and Paramedic sectors) they "ever thought about moving outside your own career structure into, for example, a Management position in the Administrative structure in the Health Board".

Focus group discussion as a method of data collection is comparatively unusual in Irish terms, although it was used by Fine-Davis (1992) in a study of the attitudinal and structural barriers to women's participation in paid employment. The method is very appropriate to exploring key themes and issues. It is particularly appropriate to exploring aspects of organisational culture, and indeed was used for this reason by the US Merit Systems Protection Board in their study of the barriers to women's promotion in the American Civil Service (Levinson, *et al.*, 1992).

It is important to stress that the paper is purely descriptive and that it focuses on the perceptions of a random sample of women, as they emerged in the focus group discussions. Recognising however that this raises issues about bias, it is worth noting that the qualitative picture is highly compatible with the statistical trends which emerged from an analysis of the Health Board's own data bases as regards men's and women's differential chances as regards promotion; the poor ratio of promotional posts in Nursing, etc. (See O'Connor, 1995a.) Thus, for example, the Health Board's own data bases showed that men's chances of promotion were two to four times greater than women's within the Administrative and Nursing hierarchies. The data also showed that one in twenty eight women had a chance of moving from permanent Staff Nurse to Matron, as compared with one in fourteen men. In these Health Boards, because of the paucity of posts at the level of Chief (and hence the use of two categories only, viz., Basic and Senior/Chief), the Paramedic hierarchy appeared to be characterised by a similar possibility of promotion for men and women. In effect however in most Paramedic areas what this meant was that one in three Paramedics could expect one promotion over their entire working life (see O'Connor, 1995a).

In the context of possible bias, it is also important to note that the focus on the organisation (as compared with family responsibilities) which underpins this paper is consistent with the trends in a "two word" individual exercise. This was where participants in all groups were asked to identify, anonymously, in one word, what they saw as the key barrier to women's promotion; and, in one word, the key improvement that could be made. In this exercise between three-fifths and four-fifths of those in the Administrative, Nursing and Paramedic sectors identified organisational factors as the key barrier to women's promotion (see O'Connor, 1995a).

It is to a more detailed exploration of the themes which emerged in the focus groups in the context of organisational culture that we now turn.

III THE PERCEIVED REALITY AND IMPLICATIONS OF A MALE HIERARCHICAL MODEL OF AUTHORITY

Weber's (1947) ideal typical model of a bureaucracy was characterised by a specialised division of labour; a hierarchy of authority with a clearly demarcated system of command and responsibilities, and by a formal set of rules and procedures. Gender was not seen as relevant since the assumption was that the bureaucrat was a depersonalised automaton (and hence obviously degendered). To him, this bureaucratic type of structure was an efficient and highly rational form of organisation (1968). Typically this is the sort of structure which is depicted as existing in the Civil Service as well as in Health Boards, etc. It is increasingly recognised that this kind of structure reflects and reinforces a "set of social relationships between men which have a material base, and which, though hierarchical, establish or create interdependence and solidarity among men that enable them to dominate women" (Hartmann, 1981, p. 10). For many of the women in this study, not only in the Administrative sector but also in the Paramedic and Nursing sectors, this very structure is problematic, implying as it does a top-down style of communication, a retentive attitude to information and a focus on "money" management rather than on "people" management. As they see it, it reflects and reinforces attitudes and ways of relating which are not conducive to the valuation of "difference".

It was very clear that many, even of the seniors in the Administrative sector of the Health Boards, perceived what they saw as the hierarchical style of Management in these Health Boards as unattractive. Those in the Administrative structure said "we don't have a team system of working". They noted that people were expected to work through their immediate supervisors, and that this meant that Management had little contact with people further down the line. Others noted that "you get the impression of so many cliques and black suits, you don't want to be part of the infighting". It was noted by those at middle and senior levels of the Administrative structure, that Management had a retentive attitude to information, so that basic information such as the breakdown of programme expenditure was not freely available. Knowledge of Health Board Policy depended on such factors as whether your job involved opening post or not. There was a strong feeling that the current style of Management was "not really attractive: the Board has to work at creating an entity, fitting you in, making people feel they belong — at present the women are outside it" (and the women make up three-quarters of the staff).

The situation as regards communication was perceived as even more acute in the case of those outside the main Administrative "line" of authority. Thus,

as the Paramedics saw it: "Communication with Management is at crisis level only"; that everyone was "covering their own butt". This sort of Management was not seen as attractive. Basic Paramedics saw "line Management" as "too hierarchical", "too rigid". They would like to see more of a "team based" approach involving both Administrators and Paramedics. As it was, the existing rigid (male) Administrative hierarchy was perceived as "intimidating". Senior Paramedics felt that Management would be more attractive if it was "more of a two-way communication on broad matters". It was suggested that those in senior Management positions could usefully adopt a more "person oriented style of Management" (as opposed to "money Management") and that this would increase the attractiveness of Management, and would enhance their own identification with it.

For the overwhelming majority of those in the Paramedic and Nursing sectors, the idea of moving into the Health Board Management structure had never occurred to them; they had never seen it as an option ("Is it possible? I've always thought well — Management is Management"). This tendency not to perceive it as an option was exacerbated by their perception of that structure as a very hierarchical male area. It was noted that to date, with one or two oft quoted exceptions, those who had gone from the Paramedic sector to Management had been male. Typically women in the Nursing and Paramedic sectors lacked information about the structure itself and about the equivalence between their own grades and the grades in the Administrative structure. Indeed, even those who were willing to accept a hierarchical model and to seek a place within it were deterred from applying for the latter by the aura created by the high numbers (Grade V; VI; VII) although the salaries of these positions were broadly comparable with their own. They referred to what they perceived as a certain resistance amongst those currently in Administration to giving (timely) information about posts in the Administration/Management area, and to the absence of an open competition mechanism to encourage those with Non-Administrative degrees to apply for them. "There is a distinct lack of information about going into Management... if people get information they tend to hold on to it". Some even seemed to be waiting to be "asked": "Nobody said to me why don't you go into Personnel". Yet there were some who were interested in a career change and felt that "there must be opportunities" if they could find out about them. Some of them noted that: "There is a kind of woolly feel about the whole Management area — you get the feeling you have to be an incredibly high flier — there doesn't seem to be information on the training or structures available". Significantly enough, some of the Paramedics noted that when they worked in England "I was pestered to go on Management courses — here you've got to grovel". Some noted that "for right or wrong women wait to be asked: they are waiting

for someone to spot talent". In this situation, those who were willing to tolerate the persistence of such a hierarchical structure (at least in the short term) referred to the importance of mentoring relationships and "work audits" and these they noted, were not in existence.

Those in the Nursing area noted that "a lot of men are going from Nursing to Administration" and they wondered "how do they get to hear about them" (i.e., the jobs). They felt that men were better at putting themselves forward: that they "will push", "that they had lots of backbone and hard neck", qualities about which they were ambivalent, but which they saw as highly useful in getting into Administration. Interestingly, those very few women who had moved into Management from the Paramedic or Nursing sectors were not seen in this light by these women. However, for a minority of those in the Paramedic sector there were issues around the image of Management: "if a women does make it in Management she seems tough"; that in order to be a good manager, especially if you were a woman, you had to be "a hard person". Those women who were interested in raising questions about the whole existence of the hierarchical structure (as opposed to more equal opportunity considerations related to their access to such positions) did not wish to abandon all organisational procedures. Rather, there was a strong belief that structures should be minimal and clearly focused on the goals to be achieved. This implied a much simpler, more open, less hierarchical concept of management than was implicit in Weber's bureaucratic model. There are similarities of course between these ideas and what Weber has called a substantive or value related form of rationality. There are also similarities with what Ramsay and Parker saw as an emerging form of bureaucracy (i.e., a neo-bureaucracy) where the focus is on capturing:

> the hearts and minds of its members in order to ensure its functioning. Since formal rules are largely absent, control must be exercised through consent and common purpose (Ramsay and Parker, 1992, p. 271).

As one might expect in view of the earlier discussion of "difference", there were obvious similarities between this sort of structure and a family context. These were implicitly underlined by the fact that for those in middle and senior levels of Administration, their relationship with their Health Board was an important focus of loyalty and identification — something which they saw as not fully reciprocated. They, like those in the other sectors, highlighted the fact that, as they saw it, Management showed little concern for those loyally and committedly working for the Board. They saw this as being reflected in the absence of cancer screening; of an Occupational Health and Safety Nurse, and/or of a confidential counselling service for staff. Several

spontaneously mentioned what they saw as the general callousness of one of the Boards in relation to the deaths of those in its employ and their close relatives. The very way it was expressed captures the basis of their involvement in the work setting: "I just felt that it was desperate" — having given your all for so long. Afterwards, if you were not feeling very well, you'd reflect am I fit for work?", (i.e., why should I treat them well when they don't seem to care about me).

The women did note that there were some positive indications that a new style of Management might be emerging: "we were asked our views (about a health education campaign): how often are you asked your views? We love to be asked to be involved". Their involvement had still been of the "cascade" variety, and although they did not use this concept, they noted that it would be even more useful to put together forums at local level involving top Management to discuss proposals for future developments before they became "blueprinted". The Management workshops in which some senior staff had participated were seen as a very useful way of increasing an understanding of the contribution of the various sectors and building communication links between them. Equally, they appreciated the emergence of a new quarterly magazine (*The Health Board News*) and saw it as an important way of making people feel part of the Health Board and keeping them in touch at an informal level. Such initiatives, although valued, were clearly seen as not challenging the core male hierarchical management structure.

Weber's ideal typical assumptions that those in the hierarchy were "depersonalized automatons" has long been criticised. However, once we accept

> that staff bring their personal interests into organisations, and that these shape the way they discharge their functions, we must also accept that *gendered* perceptions, practices and attitudes will be present too (Halford, 1992, p. 172).

It is to a more detailed exploration of this that we now turn.

IV THE PERCEIVED REALITY OF A WOMAN'S PLACE IN THAT STRUCTURE: MALE PREJUDICE AND THE CHILL FACTOR

A variety of studies have highlighted the existence and importance of attitudes and stereotypes as regards women and their place within organisations. These attitudes can be seen as affecting the promotion opportunities of individual women (and hence as phenomena which need to be tackled in an equal opportunity programme). They do, however, also reflect and reinforce ideas about "women's place" and hence raise issues about the whole way in

which "difference" is devalued within the organisation.

Such attitudes have been widely noted. Thus, the Hansard Society Commission (1990), in identifying four "general and pervasive" barriers to equality in the UK, referred specifically to "outmoded attitudes about the role of women", such as stereotyped assumptions about their ability and character and their "natural" role. Similarly Levinson, *et al.* (1992) having noted that in the US Civil Service, although women constituted 48 per cent of the employees, they only held 11 per cent of the Senior Executive Service jobs, went on to stress the importance of "subtle assumptions; attitudes and stereotypes which affect how managers sometimes view women's potential for advancement" (1992, p. 60). Exactly the same phenomenon was noted in the report on the Canadian Public Service (1990, p. 60): "It is clear however that the most significant barriers derive from attitudes", with references being made to stereotypical views about "women's place" and scepticism about their abilities. Cockburn (1991) usefully suggests that these attitudes become overt when women seek to move out of their "proper" place:

> Men reward women for sexual difference when they are in their proper place; penalise them for it once they step into men's place (p. 218).

Cockburn (1991) suggests that when they do this women are given the message that they are "out of place" — a phenomenon which can be compared with a Northern Ireland organisational culture that freezes out the minority group in that setting (i.e., Catholic or Protestant). Hence the concept of the chill factor. A similar sort of phenomenon has been identified along gender lines by Walters in the British Civil Service. She describes this as a culture "which opens itself to women and yet squeezes them out; which integrates them, yet marginalises them" (Walters, 1987, p. 14). Such attitudes and their expression in procedures which allocate women to lower status, less financially rewarding, less demanding and less visible work are not peculiar to the Civil Service, but have been documented in a variety of male dominated professional areas (see Spencer and Podmore, 1987).

This phenomenon was first described by Kanter (1977) who focused particularly on the way in which Management was depicted as male, as well as on the existence of male friendships and sponsorship networks which excluded women, and male discomfort with working with women at senior level. Kanter (1977) also suggested that for "token" women, the price of being one of the boys was a willingness to "turn against the girls". Thus even the very inclusion of such women at senior level, she suggested, reinforced what Connell (1987) has called a hegemonic masculine culture which subordinated women. Implicit in Kanter's work then is the idea that the fundamental issue is one of difference.

Comparatively little attention has been paid to this aspect of organisations in Ireland although Lynch (1993) identified such a culture as "one of the factors which poses an obstacle for women's progression in their career structure". Its existence is also very obvious indeed from a close reading of both Mahon's (1991a) work on the Civil Service and Barker and Monks (1994) on female and male accountancy careers; while Davies (1995) exploration of the predicament of Nursing rests on the analysis of the gendered (masculine) nature of organisations and their culture.

It is worth noting that in the present study some women effectively colluded with the situation. Thus for example (despite the fact that women were four times less likely to be promoted from the lower to the senior end of the Administrative hierarchy) a minority said that "there are no barriers, haven't we got promoted". They drew attention to the fact that there were individual women at Grade V, VI and "even Grade VII" and said that "anyone can go anywhere they want to". They pointed to the increase in the number of women at the middle level of the hierarchy (especially its lower end); they felt that there were more women "going through" to higher grades. In fact the Health Board's own figures showed that men were in the majority from Grade V upwards and that this pattern became more dramatic as one moved up the hierarchy. There were no women at Management Team level in either Health Board. The study was in fact initiated by the Chief Executive Officer precisely because it was perceived that such barriers did exist. In this situation, it is difficult not to conclude that these protestations reflected an identification with a patriarchal cultural hegemony, which some women endorsed as the necessary price for "acceptance" within the system.

However, for the most part there was a strong feeling amongst those in the Administrative, Nursing and Paramedic structure that prejudice existed; that it was "assumed that a man will go further"; that there was a shorter route for men than women to promotion; that Management were a lot quicker to upgrade posts held by men than by women; that women were taken less seriously by Management and had to try much harder to be promoted and would need to be at least one and a half times better to get the job. There was a feeling that men felt threatened by women who wanted to go for promotion; that when promotions were coming up, "the boys would be contacted" and as a last thought "are you interested"; that if a man and a woman were going for promotion and they were both equally qualified, the woman would be subtly discouraged and the man would be encouraged. They noted that the Senior people were men, and "where you have men, they are more likely to push for a second man", and that this seemed to happen in Nursing because they were so few men in there. However in situations where women were in a minority, a different sort of logic seemed to exist.

It was noted that frequently informal "routes" to senior positions emerged, whereby a male was selected (without interview) as an assistant to the person in a senior post ("men cloning the clones"). This was commonly seen as a signal that this was to be the next senior position holder. It was felt that men did not wish to see women in jobs that they had held: "the thing about it is that there are jobs for the boys — years in advance you know that they are going to get the job".

Those in the Administrative structure drew attention to the subtle ways in which, as they saw it, Management "up and down" put them under pressure to prove themselves, e.g., by drawing attention to any mistake they made and saying (laughing) "what do you expect? It was a women who did that". Typically, they denied that it affected them, but they did see it as part of an environment in which "you (as a woman) are proving yourself all the time". They noted that when a woman stepped into a job that had been "always" done by a man, there were those so called "humorous" comments — a kind of a dig....... you see the way females are treated; the dressing down of females by men because of their gender, the slights to women — comments made in respect of a team "It's all female", the implication being that it was bound to do poor quality work. "It is all very difficult to deal with". There were also attempts to undermine the woman by saying that: "He (the last male job holder) always used to get this done in a day" (when it might have taken the woman two or three days).

They recognised that perhaps the men did not even notice that they were doing this, or did not even recognise the effect it had in ensuring that any woman who got promoted felt that she had to give 200 per cent (in a situation where men were seen as giving 100 per cent). They also noted that it deterred women off promotion either because they did not want to give 200 per cent, or because they did not want to come under the implicit pressure and visibility that being a woman in a senior position entailed. They noted that even amongst their colleagues and juniors, some men would "expect a woman to hop" (because she was a woman).

The significance of this system of male "grooming" was heightened by the fact that it occurred within a context where there was a strong perception of male prejudice towards women. Those at the middle and senior Administrative levels saw men "as having the problem". Some went further and said that "mediocre men are in positions of power: you can only get a certain level". There was a strong feeling amongst the senior Paramedics that Management did not want assertive or well informed Paramedics. They felt that men at senior Management level still had very traditional views about women, and saw employing them as a "total hassle": if women were married, they anticipated the costs and inconveniences of Maternity Leave, and if they

were not, that they wondered "what was wrong with her". Some referred to a definite "anti-female bias" in Management. There was a feeling that women were not expected to be career oriented, and were expected to be satisfied with a "nice little job". Those senior Paramedics who had been in Management settings noted that typically they were the only women there, and at the end of it: "it was Mick, will we go for a drink"; "it was nearly automatic that the 'old boys' would go off together. If I were a man, it would be 'would you like to come for a drink' but because we are not men it does not happen". They noted that there was a lot of "buddy buddy" at Middle Management, and that this networking militated against women. There was also a strong feeling that women were deterred off applying for promotion if they had already been on Maternity Leave — almost as if Maternity Leave was a discretionary award which women should feel grateful for receiving. This feeling was exacerbated by the fact that no cover was provided for Maternity Leave in some Paramedic areas.

Nevertheless much was made, especially by those at the middle level, of the idea that (despite their own comments as regards current male prejudice in the workplace), "attitudes are changing". Some of the Administrators felt that there was another generation coming up, that the generation that had been used to "male domination" would be gone within ten years. Others were less optimistic and noted that such people were still influential and set a tone with "humorous" comments (like asking "when is this equality business going to end").

Some, such as the Paramedics, saw the problem as deriving from the fact that "there are not enough of us (i.e., women) in there. If there were enough females there to give you back-up, you'd have more confidence if more were in the same boat". Amongst those in the Nursing and Paramedic sectors, there was a feeling that if they were to be promoted into the Administrative hierarchy "you'd be the only one there — you'd be edged out by degrees. If there was a few there..... you'd like support from your own sex".

In this context targets were widely endorsed as part of the solution. The women in this study saw such measures as "the structural stuff that gives women confidence", that would "start it", "leave an opening for women", "make them encourage women", and so reduce the chance that women would be "squeezed out". There was a certain amount of regret that it should have to come to this: the dilemma being summed up as the desire "to compete equally with men if we get a fair shot".

In view of the sheer number and variety of references to male prejudice and/or the chill factor it is difficult to dismiss its perceived reality as a reflection of a lack of tolerance of difference within these organisations.

V THE PERCEIVED MARGINALISATION OF FEMALE PROFESSIONAL PROJECTS: EXPERTISE V AUTHORITY

Witz (1992, p. 64) describes professional projects as

> strategies of occupational closure which seek to establish a monopoly, over the provision of skills and competencies in a market for services.

She sees them as involving what she calls "credentialist tactics" (i.e., the making of a certain level or type of formal education a prerequisite for employment in the area) and "legalistic tactics" i.e., seeking state registration and/or recognition for the educational criteria laid down as necessary for employment in that sector). Nursing is typically regarded as a classic female professional project.

Paramedic professions are not typically seen as female professional projects. Indeed some of them were initially male professions which have become feminised. However, given the high proportion of women in most of them, particularly at Basic Grade, this depiction does not seem inappropriate. (Unfortunately, because of sample constraints it has been necessary to combine the various professional disciplines in the Paramedic area, although these are briefly referred to in O'Connor, 1995a). In any case despite their professional qualifications, Paramedics tend to be employed in areas in the Health Board where they can contribute little to the actual policy making and overall direction of the organisation, since they have in fact little organisational power. In this respect, they can be regarded as similar to Nurses and so it seems useful to see them as occupying what Savage (1992) called positions of "high expertise", as opposed to "high authority". The movement of women into such areas of high expertise but low authority is a widespread phenomenon not only in Ireland but in the EU as a whole. In both cases roughly 45 per cent of those in the professional, technical and related areas are now women (*Bulletin on Women and Employment in the EU*, 1994, No. 3, p. 1). However, as has been noted

> the increasing numbers of "expert" women in the labour market should not be seen as evidence that women are moving into positions of organisational authority but rather that, as organisations restructure, there is increased room for women to be employed in specialist niches subordinate to Senior Management although enjoying a degree of autonomy from direct control (Savage, 1992, p. 147).

It is worth noting that prior to the recognition of the gendered nature of organisations, patterns related to the distancing of positions of expertise from those of authority, and to the cultural "gap" between the worlds of admini-

stration and professional caring were typically seen as a reflection of the structurally differentiated nature of occupations. Such a depiction now seems increasing facile. (Davies, 1995). Indeed it can be seen as an attempt to selectively ignore the reality of gender within organisations — a strategy which has been identified as a mechanism of patriarchal control (O'Connor, 1995b).

A 1993 study of approximately 900 top NHS Managers (IHSM Consultants, 1994) suggested that this pattern has begun to change in the UK, with 20 per cent of the respondents in that study being from a clinical background. Even in such contexts, however, it was noted that the female Managers, whatever their backgrounds, were better qualified, and were paid slightly less than their male counterparts, in almost every sector of the National Health Service.

In the present study, salary was felt to be an important element in making Management positions attractive and for some it was "the biggest thing". As things were, a staff nurse could (with premium payments) end up earning more than her Matron and this was felt to be indicative of the low esteem in which Matrons were held. Those in the Nursing hierarchy felt strongly that such authority as had existed in positions within the Nursing hierarchy (such as Ward Sister or Matron) had been eroded. They noted that the Ward Sister post had grown "like topsy", so that you were "a bit of a counsellor, a bit of a telephonist, a bit of an electrician, a bit of a social worker", and that as women, they had, yet again, simply accepted this. They felt that this had both made the post unattractive as a promotional post, and (because of the failure to develop an Assistant Ward Sister post in General Nursing) they had effectively reduced women's chances of being promoted. Interestingly, none of them referred to the fact that the Ward Sister post was one which neither held nor controlled a budget, although in traditional (male) managerial terms, this is its most important characteristic, and a crucial indicator of its weakness as a Management post.

It was noted that the authority and financial control of a Matron had been greatly reduced. They compared this job to a Management job in a factory with 200 employees, and felt that the Matron's job was much more responsible, but also much more poorly paid. They noted that years ago Matrons had substantial budgetary control and that now they were only responsible for "salaries and premium payments". For the Matrons the ultimate insult was that this control had been given over to lay Administrators, who then further eroded their ability to foster their staff's development by not allocating them sufficient staff and funds for courses or study days. They saw these lay Administrators as being better paid and having less responsibility than themselves. Their general feeling was that the development of these

posts had blocked their opportunities as nurses, and had diminished their own position and the status of Nursing ("Haven't the men won out?").

Both those at Ward Sister level and at Assistant Matron level upwards blamed themselves and other women for "putting up" with things. They did however see themselves as the "last of a generation"; people with a vocation, who would not go on strike, and they both admired and were critical of what they saw as the more militant attitudes of a new generation of Nurses.

As those in the Nursing and Paramedic sectors saw it, there was a chasm between the (female) world of caring and the (male) administrative world. They were critical of the latter for not understanding their needs and priorities: "They have no idea of the workload. They are planning without involving those making decisions". They did not seem to realise that it was not simply a case of the coexistence of different cultural worlds, since the parameters of their working lives were in effect being set by (male) managers whose priorities were not in the caring area. Typically the issue was not seen by them in these terms. Those in the Paramedic sector simply saw this division as having an effect on their own morale: "they (Administration) don't care what services are provided and how they function, you end up not caring". Those in the Nursing sector simply stressed that "the posts are not there" when they were asked to identify what they saw as the barriers to promotion in their area. They did not see this as related to the priorities of the (male) Administrative structure, and/or to the status of Nursing as a predominantly female professional project.

As previously mentioned, the analysis of the Health Boards own data showed that their perceptions as regards posts were accurate. Thus a (female) Nurse's chance of promotion from permanent Staff Nurse to Assistant Matron level or above were extraordinarily low (viz., 28 to 1). This partly reflected men's greater opportunities, but even they had quite a low chance of promotion (viz., 14 to 1). It is difficult to avoid the conclusion that these very low figures reflect the status of Nursing as a predominantly female professional project. The position of those in Paramedic hierarchies was different as there was a one in three chance that a Paramedic would be promoted (whether they were male or female) in their own career hierarchy to Senior Chief level (gender differences existing nationally at Chief level). In fact, since at least in these Health Boards, there were typically only two "rungs" on the career hierarchy, what this meant was that one in three would get one promotion over their entire working career. Thus, their career path was in fact little better than their colleagues in the Nursing sector.

As in the Nursing area only a small minority of the Paramedics had noticed that they were very removed from the real centres of power and decision making. Thus whereas those at the top of the Administrative

structure are directly accountable to a member of the Health Board Management Team, the equivalent senior or chief Paramedic is accountable to the Hospital Administrator and/or to a Consultant, who, in turn, is accountable to a General Manager, who in turn is accountable to the Programme Manager/ Assistant Chief Executive Officer, who is a member of the Health Board Management Team. The net effect of this is that it is difficult for those in the Management hierarchy to have any appreciation of what is going on in the Paramedic sector — the "line" is far too long for anything but the most rudimentary information to filter through. As the Paramedics saw it, they had "no say in Administration except when something goes wrong or we go over budget". Thus, like those in the Nursing area, they saw no relationship between the gendered nature of their position of expertise and their remoteness from centres of authority and hence from decisions about resources.

The issues that have been described in this section in the context of the marginalisation of female professional projects can be seen as much more fundamental than those typically dealt with under equal opportunity policies. They implicitly raise issues about gendered job evaluation schemas; about the access by Managerial posts in female professional projects to control over budgets and staff resources; and about the extent to which the very structure of the organisation and its division of labour and authority, reflects and reinforces ideas about difference.

VI THE PERCEIVED EXISTENCE OF A COPING STYLE OF MANAGEMENT

Davies (1992) has suggested that despite the fact that Nursing (and indeed the Paramedic sectors) are predominantly staffed by women, gender pervades many aspects of them, and is particularly relevant to understanding what she calls a "coping" management style. She described it as:

> a firefighting approach to management that is accompanied by a strong, personal commitment to the task, a weak sense of status and position, and a willingness, sometimes quite literally on the part of the manager, to "roll up the sleeves" and get on with whatever needs to be done (p. 238).

This is often thought of as a stereotypically female style of Management. Davies argued that this style of Management arises in a situation where there is what she called "neglect by the powerful". It is both a response to that neglect and perpetuates it, since the coping Manager is too exhausted to look for additional resources from further up the hierarchy. Davies does recognise that typically with this sort of Manager there is overload, stress

and burnout amongst subordinates and a kind of isolation from senior Management bred by exhaustion, and by what can appear to be an inability to set priorities and to manage time. Davies sees the lack of priority attached to resourcing a particular area (such as Nursing) as creating what she calls a coping style of Management; and as ultimately reflecting a gendered division of labour within the professions (i.e., where particular careers are seen as appropriate for women and are part of a hierarchical structure which is gendered).

In the context of the present study, it is suggested that the emergence of a coping style of Management reflected the paucity of financial and staff resources typically allocated to women not only in female professional projects, but also indeed to women at the higher levels of the Administrative structure. It was certainly striking that the highest position held by a woman in the Administrative structure in one of the Health Boards was a co-ordinating/advisory role, with no direct line managerial responsibilities or resources. Equally, in the Paramedic sector, access even to secretarial resources was problematic, despite the requirement to produce Court Reports etc. In these kinds of situation the issue of managing resources becomes one of either managing one's own time, or somehow gaining access to other people's resources.

A coping style of Management was frequently described by those in the Nursing and Paramedic sectors in this study. It was suggested that this was related to a failure by Administration to understand the needs of their services, a problem which was compounded by the length of the Administrative hierarchy and by a kind of defensive isolation on the part of the Nursing and Paramedic Sectors ("don't hassle them in Administration") which made it very difficult for either the needs of their service or their own performance to be "visible" to Management with the Administrative structure. As they saw it, in the eyes of their own hierarchy: "if it has to go to Admin. you are in trouble"; "speaking your mind can reduce your chances of promotion: it doesn't matter if it is constructive or not ... you are seen as a trouble maker". The importance of being compliant was underlined: "If you make too many waves, they tend to cover you". This stress on "keeping quiet", "keeping your head down" made it very difficult to achieve visibility — a visibility which they felt was necessary for the service to be properly funded and/or for an individual to be promoted.

The Paramedics and the Nursing staff noted that the position of women in these areas was exacerbated by the fact that women were much more inclined than men to "take on a load of work"; to be in fact insufficiently assertive and self protective. Thus many of the Paramedics were too busy doing routine work to take the time to make themselves "visible" to what they perceived as

a very rigid male hierarchical Management structure. (Indeed it is fair to say that there was ambivalence about making themselves visible, with some viewing this as a "very empty thing".) There seemed to be a tendency to absorb the pressure consequent even on the loss of Senior posts, and a lack of political awareness as to what steps might be taken to prevent such posts disappearing. It was stressed that they knew that "a polite letter would not work", and that they felt that a man in a Senior position would not let posts be lost. On the other hand some — even of the Senior Paramedics — highlighted the difficulties of women "taking a stand" against Administration, particularly if they were working in physically isolated settings. The word "intimidation" was spontaneously referred to in a small number of cases in both the Paramedic and Nursing sectors to capture the very real pressure they were put under as individual women, to "encourage" them to fall into line.

This pressure typically occurred in the face of requests by individuals for additional resources. These were mentioned spontaneously. Typically, in these situations, a woman's request to a (male) Administrator was construed by him as an inability to take responsibility for running the service under the existing parameters. As the women involved perceived it, they were threatened by being told: "If you can't take the responsibility, I'll get someone who will". Perhaps the most important aspect of such interactions was that they were perceived as mechanisms to ensure female compliance and to perpetuate a situation where "we (women) are not willing to stir it"; a situation "where, when we are asked to jump, we'll say 'how high'". It is worth stressing that these were not frequent incidents, but that they did create a climate of fear, and one about which it was felt impossible to take action, and which exacerbated their difficulties in both "speaking up" for themselves and their patients, and in generally "putting themselves forward". They did also reflect and reinforce a situation where women, even those at middle and senior levels, were expected to discharge their responsibilities in a situation where they had very little direct control over resources.

VII SUMMARY AND CONCLUSION

This paper has been concerned with exploring the perceived reality of gendered processes within two Health Boards which are depicted as being part of the State apparatus. In order to get a conceptual handle on the reality of this aspect of organisational life, use has been made of the concept of organisational culture. The paper focuses on the perceptions of 162 women at middle and senior levels of the Administrative, Nursing and Paramedic hierarchies (response rate = 76 per cent).

Through their eyes we see the kind of organisation which is presented as "normal", viz., a hierarchical structure which is characterised by one-way communication, and a retentive attitude to information; where women's "proper" place is not in management; where the "normal" pattern of succession is along a male line; and where both traditional female projects such as Nursing, and areas of predominantly female employment such as the Paramedic sector, are characterised by a coping style of Management as they become remote from centres of resources. In this situation, the promotion of women is very unlikely. To some extent this can be seen as reflecting equal opportunity issues related to women's limited access to such positions because of male prejudice, etc. However, implicit in the paper is the idea that the problem is a more fundamental one, in so far as the very structure of the Health Boards, and the resources allocated to various sectors, reflects and reinforces patriarchal control. Furthermore, implicit in the structure, is a subordination and marginalisation of those who are "different" (i.e., women). It was shown that although for the most part the women in this study were not even aware of the structural reality of their own situation as regards budgetary control and access to resources, they did not find the "normal" hierarchical structure attractive. In so far as they were able to articulate it, the kind of organisation these women envisaged was very much in tune with current management thinking. It was team orientated, strong on communication, meritocratic in style and with an ability to use the expertise of staff, particularly when this was central to the purpose of the organisation. It implicitly involved a recognition and a valuing of "difference", and hence parity of esteem. Of course a transformation along these lines is likely to be resisted by forces within and outside the organisation, and particularly by what the women themselves describe as "mediocre men in positions of power". For change to occur, a shift in power and a restructuring of the Health Boards will be necessary. This is a very wide agenda and one which is only likely to be pursued in so far as it is ultimately compatible with other discourses such as efficiency.

Some of the changes which would be a part of a reinvisioning of such organisations raise issues which necessitate change at national and international level: they involve the establishment of gender neutral job evaluation schemes so that Nursing and other predominantly female professional projects would be revalued (and that this would be reflected in the ratio of promotional posts, level of salary, access to resources, etc.). Even in terms of more narrowly defined equal opportunity issues there is a need for a widening of the scope of positive action and a clearer definition of indirect discrimination. Changes are needed too in the attitudes and practices of those in the organisation. In particular there is a need for the recognition, through

workshop participation by Managers (from the top down) that typically they do not accept "difference", and that these attitudes like those racist attitudes in the predominantly white governed South Africa of the past, although personally real, are not socially acceptable since they militate against the effectiveness of their organisations and leave them personally open to legal actions.

This article has focused on Health Boards as an element in the State apparatus. What evidence we have suggests that similar organisational cultures are very much a reality in other parts of the State and in civil society. The importance of locating this Health Board study within the broad context of the apparatus of the State lies in its implications for the frequent depiction of the State as an unbiased employer, and indeed a neutral arbiter which will act on behalf of the weaker members such as women and children (Fahey, 1993). This article suggests that organisations such as the Health Boards are very much gendered realities. It is possible to see this as having implications not only for the State as an employer, but also for it as an agent framing policies on behalf of women and children, although this lies beyond the scope of this paper. At any rate, implicit in this study is the idea that for various reasons, and at particular times, a challenge to the hegemonic culture may be legitimated and even promoted. The extent to which this challenge will actually involve an attempt to deal with "difference" along the lines implicit in these women's views remains to be seen. However, it is worth noting that recommendations were invited as part of the study, with a view to initiating change and ensuring that all the staff in these Health Boards might be "employed at the top of their capacity" (Doherty, 1994).

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APPENDIX

Table A.1: *Classification of the Positions on the Administrative, Nursing and Paramedical Hierarchies on the Basis of Salary (indicating specimen salary ranges)**

Level	Administrative	Nursing	Paramedical
Lower	III £8,976-14,759	Staff Nurse £13,154-16,640	
Middle	IV £9,720-17,012** V £17,012-19,012	Ward Sister £16,960-18,773 Nursing Officer £18,034-19,526 Theatre Sister £17,362-19,185 Public Health Nurse £17,760-19,547	Radiographer £14,271-17,834 Physiotherapist £16,420-19,412 Pharmacist £14,116-23,507
Senior	VI £19,012-21,493 VII £19,675-23,776 Superintendent Community Welfare Officer £24,855-29,412 Management Team £26,160-32,058	Assistant Matron £17,521-21,751 Tutor £18,535-22,641 Matron £17,521-26,735	Senior/Chief/ Superintendent Radiographer £17,265-22,125 Speech Therapist £17,039-23,408 Pharmacist £23,507-29,113

*Salaries as of 1 December 1993.

**Note: For those aged 23 years or over the salary range is £13,636-17,012.