Women general practitioners

Because of the present definition of social roles, it is possible that a female physician may give considerably fewer person-years of work, perhaps as little as 60 per cent, than her male equivalent. As a result of such work patterns the investment of £40,000 in the training of an individual doctor gives a much better return in terms of years of work as a doctor if this doctor is male.

Maynard and Walker (1978).

IN 1975, 18 per cent of the active doctors in the National Health Service in Great Britain were female, and the number of women in general practice was 3,752.

Both the numbers and proportion of women in general practice have been rising steadily in recent years, and they can be expected to continue as a direct reflection of the rising proportion of women being accepted for medical training. By 1976, 35 per cent of all new medical students were female and this proportion is expected to rise to at least 40 per cent in the years ahead (Maynard and Walker, 1978).

The differential proportion choosing to work in general practice may be higher still in the future, because this branch of medicine has many attractions for women when compared with disciplines such as surgery.

The masculine bias in numbers still means, however, that in many general practices throughout the British Isles there has never been a woman partner, so the majority of women practitioners must work in partnerships without a colleague of the same sex.

Disadvantages of women doctors

The traditional view about training women as doctors has always been that it is a relatively inefficient investment because of the years lost through child-bearing and child-rearing. As training costs inflate—and the Royal Commission estimated that it cost £40,000 to train a doctor in 1977—this argument gains steadily in force.

As Maynard and Walker repeatedly comment, remarkably little information is available about what happens to women doctors after their training and exactly how much professional work is lost through their being wives and mothers. In Table 2 of the recent Royal Commission estimate of doctor manpower from 1975 to 2000, Maynard and Walker (1978) give a summary of the many surveys about the work performance of women doctors, and confirm the obvious fact that "from the point of view of professional work, the most disadvantaged group were those married with children. Only 36 per cent of these were in full-time work, 54 per cent in part-time work, and 11 per cent were unemployed".

If, however, it is assumed that women doctors have about the same sized family (2·1) as the average British family, and furthermore that they devote the whole of the pre-school years to the role of mother or during this time maintain only a limited medical role, perhaps through the doctor's retainer scheme, then it follows that it will take about seven or eight years for a woman to have two children and for the second child to reach the age of five. Even eight years, however, leaves 24 working years if the average woman doctor finishes vocational training about the age of 28 and works until she is 60.

More difficult questions are: how much part-time work will married women doctors want to undertake while their children are small? What proportion of work will they want to do once their children are between the ages of five and 15? Will they, or should they, retire at 60 when men retire at 65?

It is reasonably likely that once the youngest child is 15 or more, the majority of married women doctors will return to full-time work. If, however, we assume that they might want to work, say, two thirds time while their children are between five and 15, then the loss would be about three and a half years, thus making a total loss on average of $8 + 3 \cdot 5 = 11$ to 12 years.

Twelve years lost through child-bearing, if taken over the whole career of 32 years, could mean that 38 per cent less medical work may be done in a woman's professional life-time than in that of a man. The much more sophisticated calculations of the Royal Commission researchers led them to their very similar conclusion that women may work as little as 60 per cent of their male equivalents (Maynard and Walker, 1978).

In addition to this central disadvantage, from the Government's point of view, about encouraging women doctors, there are at least two other factors loaded in the

scales against them. The first is their greater sickness rate, particularly in the 30- to 50-year-old age group—their compensating greater longevity is little consolation to prospective employers. Furthermore, employers and colleagues are increasingly finding that the demands of children, including breast feeding, unexpected illness, or family commitments, make female physicians less reliable sources of cover in many medical rotas, even when working part time.

Finally, there is concern that some younger practitioners, and especially married women, are accepting posts as principals but are providing surprisingly little personal continuing care.

The advantages of women practitioners

Given the historical diminution of the role of women in society, it is hardly surprising that there remains in the medical profession much latent prejudice (Davidson, 1978). The struggle described so graphically by Bell (1953) in *Storming the Citadel* can still be seen only as the all important first step of a continuing struggle for equality. The medical profession can, however, be proud that, having once accepted women as full members of the profession, which it did far ahead of its time and far ahead of the Church, it has insisted on equal pay and equal opportunities.

What, however, has not yet been done, and what now urgently needs to be completed, is a systematic attempt to document not the disadvantages but the *advantages* that women have in general practice. It is one of the failures of the first generation of women in general practice that they have so far failed to produce objective evidence of their own rather special role.

There are several theoretical reasons which suggest that women may be particularly suited to primary medical care, a conclusion which, albeit in very different circumstances, has long been accepted in the USSR.

The first and most obvious fact which has been replicated in study after study across the Western world is that women consult in general practice more than men (Royal College of General Practitioners, 1976). Women come to general practitioners for many reasons, and it is possible that women doctors understand many of their complaints more quickly, if not more deeply, than men. If feeling what the patient is feeling is a principal objective of vocational training (University of Exeter, 1977) then a doctor of the same sex should be at an advantage. Having shared experiences, especially those of menstruation, pregnancy, labour, and child-rearing, is likely to heighten, not diminish, a physician's sensitivity. The large number of conditions which are exclusive to the female sex, including the mass of gynaecological complaints, seem ideally suited to women physicians. In any case, at least a substantial minority of women would, if given a free choice, prefer to consult a female practitioner.

A powerful argument which favours women, especially wives and mothers, is that they will bring to medical practice a richness of experience which can only enhance their profession and practice. The medical profession has for long emphasized the advantages of mature (usually male) entrants to the profession and tolerated with equanimity their reduced contribution in "person-years of work". Perhaps this argument can now be extended to the female sex.

Another point is that about a quarter of a family doctor's work is with children (Royal College of General Practitioners, 1978). Although many men are both caring and competent, and extremely skilled at handling babies and children, it nevertheless seems likely that many of the common problems of child-rearing may be more comfortably faced by a woman, especially married, rather than a man doctor.

Because so much geriatric work is about care rather than cure, and because so many of the very old are women themselves, a rising proportion of women practitioners can only be welcome.

There remains another more subtle principle. It is at least possible that the female is either biologically or culturally more appropriate than the male by having an inherently less aggressive attitude. Stevens (1978) has described the "nurturative female mentality" in contrast to the "aggressive male instrumentality" and suggested that situations where dynamic, active, highly technical interventions are needed may be inherently more suitable to be dealt with by men, while a more passive, more relaxed, lower profile relationship may appeal rather to women. What is of special importance, if this be true, is the changing role of general practice from the dominant, active, interventionist philosophy to a much more passive, nurturative, counselling relationship. If counselling does become the normal mode of consulting, and if primary care does become increasingly concerned with caring rather than curing, then women may be particularly well suited to this job.

If this is so, the striking under-representation of women in medicine on almost all executive committees of importance is serious indeed, and the even greater under-representation of married women a potential time-bomb. Although the Royal College of General Practitioners was proud to have a woman President and Chairman of Council within its first few years, it now has only one woman member of Council. There is only one woman regional adviser in the British Isles and strikingly few woman university lecturers or course organizers. In the South Western Region in 1978, of 115 trainers there were only three women trainers and only one was married.

Flexibility

Flexibility could be the key. Married women doctors need considerable encouragement. Those working in general practice will increasingly require part-time posts for at least some of their professional careers. General

practice is fortunate to have retained the independent contractor status which is the most flexible administrative instrument so far devised to accommodate a wide variety of different situations and a tolerance to different demands at different times. A flexible approach in partnerships, perhaps modelled by general practitioners who already have fixed commitments outside the practice, such as clinical assistantships or lectureships, may prove appropriate.

Welcome

What is now required is the will to create the part-time opportunities which some younger women doctors are already seeking. Given the will, general practice will surely find a way.

We welcome the progressive influx of women general practitioners, which is now overdue. Half the population are women and more than half the patients. We are confident that women practitioners will greatly enhance the quality of care in general practice in the years ahead.

References

Bell, E. M. (1953). *Storming the Citadel.* London: Constable.

Davidson, V. M. (1978). Coping styles of women medical students. *Journal of Medical Education,* **53**, 902-907.

Maynard, A. and Walker, A. (1978). *Doctor Manpower 1975 to 2000: Alternative Forecasts and their Resource Implications. Research Paper Number 4.* London: HMSO.

Royal College of General Practitioners (1976). *Trends in National Morbidity. Occasional Paper 3.* London: *Journal of the Royal College of General Practitioners.*

Royal College of General Practitioners (1978). The care of children. *Journal of the Royal College of General Practitioners,* **28**, 553-556.

Stevens, J. L. (1978). Lecture at Exeter Postgraduate Centre. Unpublished.

University of Exeter (1977). Prospectus for the Department of General Practice. Exeter: University of Exeter.

The General Medical Council

THE General Medical Council is important. Formed in 1858 as the governing body of the profession, it has retained for over 120 years supreme responsibility within the profession, both for education and for ethics. Its existence as a statutory body with representatives from the profession itself, the universities, and the Privy Council, presents an interesting symbol of professional autonomy, and indeed this has been described as one of the characteristics of a true profession.

However, during the last 15 years there has been a growing challenge to the structure and functions of this body in relation to changes both in medicine and society.

Through a series of most unhappy events, culminating in widespread unrest within the medical profession, the Merrison Committee was appointed to report both on its structure and its functions. Its skilful report has commanded widespread approval and has led in its turn to the introduction of a voting system in which the majority of new members of the new General Medical Council (GMC) will be elected democratically by the profession.

About 50 places will be filled on a regional basis and there will be separate constituencies for England, Wales, Scotland, and Northern Ireland.

Nominations

General practice as the largest single branch of the medical profession has been strikingly deprived of fair representation on the General Medical Council. Although there are over 25,000 general practitioners in the United Kingdom, at present there are only four general practitioners out of 46 members, and only two of these come from the whole of England. Under the new reform any registered medical practitioner can be nominated for election and it is to be hoped that for the first time general practice will have an opportunity to be fairly represented. Those nominated must, however, be prepared to devote up to four weeks a year to the duties of the General Medical Council, whose meetings are held in London. There is also a welcome age limit for membership of the GMC.

The voting system

The new Council of the GMC will have 96 members, of whom 50 will be elected. In the past the profession has shown an unfortunate apathy in voting: at times only one third of the electorate have exercised their privilege of voting. Whatever the views of doctors in relation to society, this is an important opportunity to take a practical step towards seeing that these views are reflected in the profession's governing body. A vote missed is not merely a vote wasted—it represents in effect the handing over of power, possibly to extreme groups in the profession.

The Royal College of General Practitioners even today has no representative on the GMC, unlike all the older Royal Colleges. This anachronism is also about to be changed and under the new constitution the College will have the right to nominate its own representative.

Nevertheless, too much cannot be expected from any one individual. What is important now is that all members of the College think carefully about who will be best suited to represent general practice on the GMC and the educational policies for which the College stands. General practice can fairly claim to have introduced more educational changes in the last 15 years than any other branch of the profession. It still has much to learn; but it can claim to have much to give.

Faculty boards have already been asked about possible nominations. However, nominations are not restricted to organizations: on the contrary, in-