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# LETTERS TO THE EDITOR

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## WOMEN GENERAL PRACTITIONERS

Sir,  
While I appreciate what you may be *trying* to say in your editorial about women general practitioners (*April Journal*, p. 195) I feel as a woman general practitioner that there are some serious flaws in your reasoning.

First of all, women lose a lot of time in child bearing and rearing because there are not enough provisions for child care, such as crèches and shared jobs. Secondly, why can men not take time out to look after children—in most doctor/doctor marriages it is still the woman who takes time off.

Thirdly, you talk about women being good at 'caring' as opposed to 'curing'—surely all the important medical advances have been made *not* by 'curing' but by improved nutrition, hygiene, and housing. All doctors should be 'caring': it is not a female role. There is also no evidence to show that women are 'biologically' less aggressive than men.

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Sir,  
Your editorial (*April Journal*, p. 195) was timely and you are to be congratulated on drawing attention to this important and sensitive topic. Faculties have recently been sent a discussion paper on a similar theme and their comments will form a major contribution to what promises to be a very interesting College debate (Norell, 1979). However, the question faculties have been asked to look at is not, What can general practice do for women doctors?, but, What are women doctors doing to general practice?

You are rightly concerned that women doctors appear to be relegated—or are relegating themselves—to less responsible roles within general practice, but if the debate is to be properly informed and productive it will have to be free from the sentimental and patronizing special pleading which has characterized it so far and which must have left many of our women colleagues squirming with embarrassment.

General practice is not and never has been static: clearly there are going to be

further changes. But what is it that has to change? And how much?

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### Reference

Norell, J. (1979). *Woman's work*. Unpublished.

Sir,  
I think the publication of your editorial on women general practitioners (*April Journal*, p. 195), which in pseudo-scientific fashion dubs them as more "unreliable" and "passive" than their male counterparts, is not only insulting to women but very damaging to the image of the Royal College, at least in the eyes of a large number of women.

Why do men have the monopoly on dynamism and technical expertise and women the monopoly on absenteeism and illness (both as doctors and patients!)? I have rarely come across a worse case of arrant prejudice—it is a shame that the doubtful worth of statistics should be combined with subjective opinions in an otherwise august journal such as yours for the purpose (only thinly disguised) of showing that, yet again, the female gender is 'inferior'.

At the risk of sounding rather 'female chauvinist' I should like to give vent to a few observations of my own, equally as unscientific as yours, but more convincing for their sheer reality.

If women are more prone to illness and unreliability (and I do not entirely accept this) it is not because of some "biological" reason—it is more the product of conditioning and circumstances in most women's lives. Is it surprising if women are more often ill or mentally run-down when many of them have two jobs, one at work and one at home and have to look after the children as well—what also of the evergrowing minority of women with young children deserted by husbands (men are such 'reliable' creatures, aren't they?) who cope alone with the job and the home? What of the women who care for invalid relatives, a job which men would spurn (and do) who also work?

As for the implied lesser amount of dynamism and action we women have, this is sheer nonsense. Many women I know cope successfully with extremely complex lives filled with responsibilities, where being non-dynamic

would soon lead to disaster. Of men and women I know, women are far more energetic and dynamic. I myself worked every day full time until the day I gave birth to my son, right the way through pregnancy (I was living in Sweden and it is common for women to work until they get labour pains). I did my work efficiently and also lifted bits of heavy machinery and often had to correct and improve the work of my (male) bosses. So you can see why I scorn such opinions on women, whether general practitioners or housewives.

I hope you will either publish this letter in your *Journal* or do something to offset the disastrous effect of such an editorial on people's minds.

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## SHOULD WE LOOK FOR GONORRHOEA?

Sir,  
I enjoyed the articles on vaginal discharge by Dr Hull (*December Journal*, p. 714) and vaginal candidosis by Drs Wright and Palmer (*December Journal*, p. 719). However, neither touched on the problem of gonorrhoea, which is a disease with potentially serious consequences and is increasing in frequency (Morton, 1970).

There is evidence that we do not look for it. Vaginal discharge is common: most general practitioners see one or two cases each week, and few are referred. In a recent survey organized by the Beds. and Herts. Faculty, of 124 patients seen by 38 general practitioners, only 12 were referred. Raphael and Levy (1977) failed to grow the gonococcus in a survey of patients, but they used only high vaginal swabs, which are known to give a lower yield of positive results than cervical, urethral, and rectal swabs. Hull does not mention cervical and urethral swabs.

Should we always look for it? How common is it in general practice? A routine screening of symptomless patients seeking contraceptive advice yielded 0.4 per cent. Would it be commoner in patients with symptoms? Is clinical suspicion or knowledge of the patient adequate? I think the answer is 'no'. It would be logistically impossible and probably undesirable to refer all patients to genitourinary clinics. We