LETTERS TO THE EDITOR

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 crêches 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 Unpublished.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

have one particular source of double think: if we isolate *Trichomonas vaginalis* we congratulate ourselves instead of increasing our search for gonorrhoea, since gonorrhoea and trichomonas are known to be associated.

We need Drs Wright and Palmer to repeat their experiment using the gonococcus. How long will it live in transport? Is 'Transgrow' a better medium than Stuarts? If we can get an answer to these questions we need a survey in general practice to find the incidence, so that we can make decisions on investigation and management of all patients. Meanwhile, should we at least be aware of the problem and attempt to diagnose gonorrhoea?

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References

Morton, R. S. (1970). Male/female ratios in the VD clinics of England and Wales. British Journal of Venereal Diseases, **46**, 103-105.

Raphael, M. & Levy, B. (1977). The value of vaginal cultures in general practice. *Journal of the Royal College of General Practitioners*, **27**, 349-351.

CORONARY DISEASE, HYPERTENSION, STROKE, AND DIABETES

Sir,
A subgroup of the College Working Party on Prevention has been set up to study prevention and anticipatory care of coronary disease, hypertension, stroke, and diabetes, and we are at present trying to draw up a working document that will review present evidence on what can be done, what general practitioners are doing now, what in fairly practical terms they might do in the future, and the new resources that would be required for this.

Although we know that much innovatory work is going on here and there all over Britain, little of it has been published, and there has not been much public discussion of the real problems encountered and opportunities revealed.

It would be extremely helpful if any doctors who have run or attempted to run their own hypertension or diabetes clinics, or who have organized or attempted to organize various forms of screening activity, patient education, smoking control, or any other forms of active outreach to the public at risk, could write to me outlining the main lessons they think they have learned from this. I cannot undertake to do more than acknowledge these, but our working group at present feels very ignorant of what our colleagues are doing.

It is all too clear what we are *not* doing, but if anyone wants to write about any outstanding experiences of this negative kind, that might be useful too.

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ACCESSIBILITY OF PRIMARY CARE

Sir,
A number of local general practitioners have commented on the article by Dr P. L. Knox on 'The accessibility of primary care to urban patients: a geographical analysis' (March *Journal*, p. 160). We wish to bring the following points to your attention:

1. There are no health centres as indicated in Figure 2. These are long established 'local authority' clinics, where certain general practitioners hold branch surgeries.
2. In 1950 general practitioners' surgeries were mainly in their own homes, whereas by 1973 many doctors rented premises in a locality which suited their practice.
3. The time taken to travel one mile in Aberdeen must vary considerably between the central area and some of the peripheral council estates.
4. Kincorth is the area of Aberdeen with the most compact practice. The surgery facilities provide a high standard of team care. If patients from Kincorth choose to go to another practice, that is their choice.
5. The paper by Richardson and Dingwall-Fordyce (1968) which is quoted, counters the argument that a few practitioners have "an excessive load of long-distance visiting". Indeed the criticism that might be made of general practices in Aberdeen is the lack of zoning. The same study was used to gauge "the effectiveness of alternative locations for new resources" when the decision was made on the building of Denburn and Foresterhill health centres.
6. There seems to be a lack of knowledge of the pattern of general practice in Aberdeen, and it seems odd that Dr Knox apparently did not discuss his method or conclusions with any of the authors of previously published papers on practice geography in Aberdeen.
7. Dr Knox appears to have given insufficient consideration to the fact that general practitioners cannot realistically be expected to build premises in anticipation of their having a use in new housing schemes. These could never be economical unless initial practice allowances were available, and Dr Knox will realize that this would not be the case in Aberdeen where the average list size is so favourable to the patient.

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Reference

Richardson, J. M. & Dingwall-Fordyce, J. (1968). Patient geography in general practice. *Lancet*, **2**, 1290-1293.

Sir,
It may have taken an 'outsider' like Dr P. Knox to show in his article (March *Journal*, p. 160) that we may not be readily accessible to the patients who need us most.

Many patients are prepared to travel long distances to attend their general practitioners but these tend to be the ones who are coping with life satisfactorily: the more deprived members of society must have readily available surgeries.

The problem is most acute in the peripheral housing estates where there may be many problem families who, along with problems such as vandalism to surgery buildings, make these areas less attractive to general practitioners.

Branch surgeries in the peripheral areas are not satisfactory, as general practitioners remain emotionally committed to their central premises, and zoning is not popular with doctors or some patients. However, scattered surgeries create many problems for attached staff working in patients' homes and prevent integration of the practice with the local community.

Doctors must be attracted to these areas by high quality premises and adequate attached staff. 'Drafting' will only perpetuate a second class service.

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HOME VISITING

Sir,
Congratulations to Dr Bailey and his colleagues on their article "Home