among women—from 41 per cent to 38 per cent.

The total fall in prevalence was due mainly to the fall in the proportions of men and women who were light smokers (fewer than 20 cigarettes a day); the proportions of men and women who were heavy smokers (20 or more cigarettes a day) remained fairly constant, so average weekly cigarette consumption rose during that period.

Between 1976 and 1978 prevalance fell from only 46 per cent to 45 per cent among men and from 38 per cent to 37 per cent among women.

Reference

Office of Population Censuses and Surveys (1979). General Household Survey 1978. *OPCS Monitor,* GHS 79/1, 29 May.

LETTERS TO THE EDITOR

WOMEN GENERAL PRACTITIONERS

Sir,

Your editorial (April *Journal,* p.195) on the plight of women doctors was sensitive, timely, and welcome.

You mention some of the reasons why others regard women as a 'disadvantaged' group (Maynard and Walker 1978). I cannot accept it wholly that married women doctors with children are at a disadvantage *because* they are married with children. There are other married professional women who are able to combine their careers with family commitments.

One of the more realistic disadvantages of married women doctors is their relative lack of mobility. If the career prospects of a man take him from one part of the country to another, his doctor wife will be restricted to those opportunities that are available to her in the locality of her husband's work, and if she finds a practice—unless her husband is established—her partners will be rightly suspicious that she will stay in the practice for a limited time only.

I submit that it is up to the couple to decide whose career opportunities will determine the permanency, or even relative permanency, of the woman doctor's place of work—preferably before they marry. It is perfectly possible to plan one's career as well as one's family—and even in the absence of domestic help, perhaps it is not beyond the ingenuity of a couple to plan their life to deal with childhood illness, fetching the children from school, and all the other 'problems' which are part of normal living.

I feel that, while of course there are events in any family's life that will make it more difficult to cope with work, the sudden discovery of the married women doctor's 'special situation' is but a forerunner of the discovery that doctors' attitudes to their work *have* changed in general. In the past, doctors moulded their private lives around their practices—now more and more the practice is being moulded to suit the doctor's private life.

Some doctors are men and some are women, and the contribution they make to their practices depends on their skills, knowledge, and attitudes—above all, on their human qualities, on their ability to marry *Scientia* with *Caritas.* And it is their ability which should make them participate in continuing education, in executive committees, and in organizing vocational training courses, and even represent their faculties on College Council. They should be there not as women or men, but as doctors, with a special contribution to make.

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Reference

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

Sir,

"Married women doctors need encouragement" proclaims a recent editorial (April *Journal,* p. 195). But they also need jobs, and other statements in your otherwise sympathetic article may make it more difficult for them to obtain these.

You find it necessary to justify "latent prejudice in the medical profession" with a reference. You should have done the same for three other comments. Data, please, to prove that women doctors lose more time for sickness in the 30 to 50 age group; that prove married women principals are providing inadequate personal continuing care, and who precisely thinks employers and colleagues are finding female physicians less reliable sources of cover. I cannot believe that women doctors alone use the deputizing services.

Your *Journal* is widely read and these statements have already been quoted in the national and medical press. You should either provide evidence for them, of a quality you would normally require to substantiate statements in the remainder of the *Journal,* or publish a retraction.

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Sir,

I must thank you for the very understanding editorial about women general practitioners. I like your general conclusions. The understanding of caring is basic and at times it can be a noose around our own necks. There is a risk of becoming irritable, but that is a weakness *we* do not recognize.

The paragraph on flexibility is very good. It provides the answer to our fewness on committees or councils, which must by their nature be at fixed hours; when they last for a day or so and at a distance we fear them greatly. Tolerant husbands are not referred to—they can make the whole difference to availability and to success!

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Sir,

It is unfortunate that a national newspaper should highlight your editorial (April *Journal,* p. 195) with the phrase "women doctors less reliable than men". I do not dispute that our biological function may limit some in their contribution to a medical career for varying lengths of time but I cannot accept that we have a greater sickness rate. You, fortunately, have not produced any statistical evidence in support of your claim, and I have been unable to find any to disprove it. Are male colleagues not at greater risk from

alcohol and more likely to emigrate?

The medical activity of women doctors is rising and has increased from 66 per cent in 1965 to 79 per cent in 1974 (Ford, 1979). The medical activity of fully and provisionally registered male doctors is quoted at 88 per cent in these years. Unfortunately there are no figures available which show if those medically active are working part or full time but a national survey of the activity of women doctors is expected from Sheffield at the end of 1979.

The editorial is concerned that young married women who are principals are providing surprisingly little personal continuing care in general practice. I feel the same could be said of many male colleagues who spend up to five weekly sessions working in hospital, in industry, or as police surgeons, not to mention those who spend more time in medical politics.

Women do bring a new dimension of caring to general practice; the editorial acknowledges this and I am sure even if working a set number of hours the woman practitioner gives an excellent service and may contribute more in her shorter day to primary care than her male colleague who remains uninvolved and leaves the care of the practice to others.

Flexibility must remain the keyword of both training and the career post in general practice. Married women doctors are attracted to general practice but have been discouraged in some regions where they have not been given the opportunity to be true partners with their own list of patients and involvement in the organization and management of the practice. If they have the support of their partners at the time when their domestic responsibilities are great, they will contribute a great deal to primary care and willingly increase their commitment as these responsibilities lessen, emerging after a few years to give full continuing care and become involved in training and committee work.

GMSC Representative, Joint Committee on Postgraduate Training for General Practice

5 Minard Road
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Reference

Ford, G. (1979). Paper presented at Medical Women's Careers Symposium 1979. Unpublished.

Sir,

Thank you for your encouraging words to women general practitioners (April *Journal,* p.195). My experience as a mother and doctor who qualified in 1943 and has worked full time happily ever since has taught me that it can be done if the opportunity is forthcoming.

While wishing my young colleagues the full enjoyment of their motherhood, I do not think it necessary nowadays for them to resign themselves to the retainer scheme or part-time clinics.

The modern helpful husbands are ready to share the household chores. They discover that to care for children increases their enjoyment. This fact is a great gain for the young woman doctor.

Most of my female colleagues, aged 60, are fitter than their male counterparts (probably because we have kept mobile doing our housework). I see no reason why in the name of equality we should not demand our time of official retirement to be raised to 65 years.

I am in full agreement with Dr M. J. Whitfield's article on community clinics (April *Journal,* p.240). The young women doctors with household obligations are best suited to help us bring their preventive clinics into the framework of our primary care teams where they belong. If these doctors work half days, two doctors working as a unit within a group or a health centre could enrich the primary care team. These women doctors probably understand adolescents, abortion, and young mothers better than most. Besides, women doctors might guide us all to a more sensible diet. I am so glad that my young and gifted female colleagues take more interest in healthy cooking than my generation ever did.

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Sir,

As a woman general practitioner I was very interested in your editorial (April *Journal,* p.195) and would like to comment on some points.

First, I agree that a woman who takes time off or works part time when she has children obviously gives a reduced time to medical practice, but I think that the way you arrived at your figures is biased. Why do you take the end of vocational training as the start of a medical career? Most people feel that this starts when they pass finals. Why not take women's increased longevity into account if it means that more men than women die before retiring age? Is there any difference between emigration rates and rates of loss to other professions which should be taken into account? If all the relevant factors are not included the use of figures is meaningless.

You state that there is a greater sickness rate in women doctors. I know that some but not all sickness insurance companies charge more for insuring women doctors and the Department of Health and Social Security can demonstrate that women in general make more short-term claims than men, but the Medical Women's Federation in their recent newsletter say that they can find no evidence that women doctors are away from work for more time than men. Do you actually have any evidence to support your statements?

There is no mention either of the increased remuneration given to practices taking on a partner rather than an assistant. This, with the favourable attitude of the Medical Practices Committee to women entering practice on a part-time basis, has led to practices preferring to take on women as salaried partners rather than as assistants. This has been to our advantage, but if the Vocational Training Act is implemented it will mean that there are fewer assistant posts for women who, because of individual circumstances, cannot do the formal vocational training but want to obtain the certificate of equivalent experience, or indeed just want to work in practice without it.

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There is good evidence that women are in general subject to a higher sickness rate than men (OPCS, 1974; RCGP,

Females compared with males. Actual weeks of claim for sickness (males standardized at 100). All deferred periods combined.

	Age group							
Sickness period	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59
1 to 3 days	85	188	150	196	138	168	118	156
4 to 9 days	142	139	184	202	146	206	136	172
13 weeks	241	157	259	150	227	135	121	161
26 weeks	207	301	428	197	263	141	135	126
52 weeks	29	184	385	488	233	143	128	129
Over one year	0	0	41	195	160	303	60	186
All periods	144	167	241	224	192	206	100	162