

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
Glasgow G41 2HR.

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 Unpublished.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.

JOSEPHINE BRUEGEL

Temple Fortune Health Centre
23 Temple Fortune Lane
London NW11 7TE.

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.

A. BRYAN

31 Colcot Road
Barry
South Glamorgan.

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.

Sickness period	Age group							
	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

1976). Furthermore, women make claims on sickness policies significantly more than men and many insurance companies reflect this with higher premiums for women clients.

The above table from an article submitted to the Journal of the Institute of Actuaries gives further factual evidence—Ed.

References

- Office of Population Censuses and Surveys, Royal College of General Practitioners & Department of Health and Social Security (1974). *Morbidity Statistics from General Practice. Second National Study 1970-1*. London: HMSO.
- Royal College of General Practitioners (1976). *Trends in National Morbidity. Occasional Paper 3*. p. 10. Table 3. London: *Journal of the Royal College of General Practitioners*.

HAY FEVER

Sir,

In the prize-winning essay on hay fever (*May Journal*, p.265) it is said that cell-mediated immunity is mediated by IgE. My understanding is that IgE is an antibody involved in anaphylaxis which is classed as humoral immunity, while cell-mediated immunity involving reactions such as delayed hypersensitivity and graft rejection involves the T-lymphocytes, and not IgE.

As the essay is entitled "The management of hay fever in general practice" it is a pity that it does not really discuss the evidence for and against skin testing and desensitization. It is also surprising considering that when quite a lot of space is devoted to immunology no mention is made of the mechanism of desensitization, which I believe involves IgE 'blocking antibodies'.

Finally, the three full pages of references, 175 in all, must be a record. Unfortunately many seem to come straight from the pages of *Index Medicus* without being discussed in the essay, whilst many contentious points are made without any quoted references.

ROBERT FIELDS

Kingswood Health Centre
Alma Road
Kingswood
Bristol BS15 4EJ.

JAMES MACKENZIE LECTURE

Sir,

Professor J. McCormick has challenged (*April Journal*, p.248) my statement in

the 1978 Mackenzie Lecture (January *Journal*, p.7) that in Mackenzie's day coronary thrombosis "was not there". He supports his belief that Mackenzie "encountered many infarctions" by referring to case histories described in Mackenzie's two books *Diseases of the Heart* (1913) and *Angina Pectoris* (1923) suggesting that "in many instances cases are supported by careful postmortem evidence".

Study of these books reveals no support at all for Professor McCormick's viewpoint:

1. Of the 160 cases detailed in *Angina Pectoris*, only 22 were subjected to postmortem examination which Mackenzie described as "somewhat imperfect". Of the 22 postmortem cases, at the very most 10 demonstrated myocardial degeneration due only to ischaemia associated with coronary atheroma. The remainder had suffered from rheumatic endocarditis, syphilitic aortitis, or from some other disease.
2. From the histories of the 138 cases not subjected to postmortem (some were still living at the time of writing) it is impossible in many instances to make any diagnosis at all. Some were probably functional, others appeared to be suffering from rheumatic or syphilitic cardiac disease, or from diseases of the lung, or from cancer.
3. The importance of valvular disease or syphilitic aortitis as a cause of angina in those days is further demonstrated by Mackenzie's statement (*Angina Pectoris*, p.89) that 90 cases of angina—presumably out of a total of 284 whose deaths he had recorded—were associated with aortic incompetence and that "angina pectoris in early life always raises the suspicion of syphilitic aortitis" (p. 78).
4. I could find no record at all of death occurring within 48 hours of onset of angina in a previously healthy patient.
5. Nor could I find any record of typical non-fatal attacks occurring in a previously symptom-free patient.

For an understanding of the history of coronary disease it is essential to remember the two main manifestations of anginal attacks (Michaels, 1966).

The first manifestation, due to coronary ischaemia progressing over a number of years, often going on to death in old age when the myocardium may be found to be degenerate and fibrosed, was first described by Heberden in the eighteenth century (Heberden, 1802). It was not very common until the present century (Osler, 1910). Mackenzie himself suffered from this form of angina.

The second manifestation—sudden infarction coming out of the blue in a previously symptom-free patient, en-

ding in death within a few days or in recovery—is now so common that it is often described as an epidemic. No description of this second manifestation appeared in medical literature before the present century. It was not recorded in Edinburgh before 1928 (Gilchrist, 1971) and it does not appear to have been known in Glasgow in the mid-1920s (Henderson, 1964). We still do not understand the pathology of coronary thrombosis (*BMJ*, 1979) nor the relationships between thrombus formation and arterial disease, but I believe there is no doubt at all of the fact that widespread infarction striking men in their 40s, 50s, or 60s in large numbers is a new disease of the twentieth century.

I am sorry that Professor McCormick found part of my lecture "impossible". I was merely trying to say that if we are to understand the cause, and so prevent the degenerations which beset us, we must study nature's laws and seek to obey them. If some readers find this theme impossible I doubt if I can help them, but I implore them at least to read some of my references, particularly *The Saccharine Disease* (Cleave, 1974) from whose work so much of my material and inspiration originated.

Before shrugging it all off as "impossible" readers should be reminded that Cleave has this year been awarded the Harben Gold Medal for his services to public health, an honour which he thus shares with names such as Pasteur, Lister, Koch, Ross, and Fleming.

WALTER YELLOWLEES

Inzievar
Aberfeldy
Perthshire.

References

- British Medical Journal* (1979). Coronary artery spasm. Editorial, 1, 969.
- Cleave, T. L. (1974). *The Saccharine Disease*. Bristol: John Wright.
- Gilchrist, A. R. (1971). Personal communication.
- Heberden, W. (1802). *Commentaries on the History of Cure and Diseases*. Facsimile reproduction (1962). New York: Hasner Publications.
- Henderson, J. M. (1964). Looking back to Mackenzie. James Mackenzie Lecture 1963. *Journal of the Royal College of General Practitioners*, 7, 9-23.
- Mackenzie, J. (1913). *Disease of the Heart*. 3rd edition. Oxford: Oxford University Press.
- Mackenzie, J. (1923). *Angina Pectoris*. London: Frowde & Hodder & Stoughton.
- Michaels, L. (1966). Aetiology of coronary artery disease and historical approach. *British Heart Journal*, 28, 258-264.
- Osler, W. (1910). Angina Pectoris. *Lancet*, 1, 697-702.